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

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

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

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

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

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

WellCare Health Plans (WellCare) thanks the Senate Finance Committee for seeking stakeholder input on thoughtful policies to improve care for Medicare beneficiaries with chronic conditions. We are pleased to submit the enclosed information in response to your request for comments from health care stakeholders, distributed on December 18, 2015.

Nationally, WellCare is one of the country's largest health care companies dedicated solely to serving public program beneficiaries. We currently serve more than four million enrollees nationwide, and offer a variety of products including: Prescription Drug, Medicare Advantage (MA), Medicaid, and Children's Health Insurance Program (CHIP) plans; for families, children, and the aged, blind, and disabled. Over half of our members are dually eligible for both Medicare and Medicaid. WellCare's mission is to be the leader in government sponsored health care programs in partnership with enrollees, providers, and the government agencies we serve. This mission drives our business and we design our products and support services in accordance with that mission. We have a long standing commitment to our federal and state partners to deliver value, access, quality, cost savings, and budget predictability. It is from this vantage point that we offer these comments.

Issue 1: Receiving High Quality Care in the Home

Option 1: Expanding the Independence at Home Model of Care and Care Management for Chronic Conditions

WellCare supports expanding the Independence at Home (IAH) demonstration into Medicare Advantage (MA) in order to further the delivery of the appropriate care at the appropriate time in the appropriate setting, and to ensure that beneficiaries do not unnecessarily utilize hospital emergency departments. We support using the Hierarchical Condition Categories (HCC) model as a way to identify beneficiaries for inclusion in the program as opposed to risk scores because additional factors such as geography and gender contribute to risk scores. The Centers for Medicare and Medicaid Services (CMS) recently proposed a change in the risk scoring system that would assign a different risk score for a full benefit dual eligible, a partial benefit dual eligible, and a non-dual eligible beneficiary. In the newly proposed model, two individuals with the same HCCs but different eligibility groups could potentially have different risk scores. Incorporating dual eligibility status into the risk calculation is a more accurate way to determine a beneficiary's actual health status. We support the recently proposed model and encourage the Committee to also look at the same HCCs and disease intersections in the Medicare fee-for-service (FFS) population to ensure consistency in identifying individuals who would potentially benefit from the IAH demonstration. Additionally, in order to assure that these services are appropriately incorporated in the MA program, we recommend that all services covered under the IAH demonstration are included by the Office of the Chief Actuary (OACT) in setting yearly MA rates.

Issue 2: Advancing Team-Based Care

Option 1: Providing Medicare Advantage Enrollees with Hospice Benefits

When beneficiaries and their families are facing the difficult decision of shifting from curative treatment to palliative care, navigating the Medicare system to identify the payer of each service can add unnecessary stress. WellCare supports the inclusion of the hospice benefit as an MA covered benefit. The requirements for election, including a signed statement choosing hospice care instead of other Medicare-covered treatments for terminal illness and related conditions, should be the same for both MA and Medicare FFS. Accordingly, CMS should include all hospice costs, including pharmacy costs, in the benchmark calculation.

Further, in situations where a Medicare beneficiary elects a hospice benefit, the payment for his or her pharmacy costs is often split between the Medicare Part A hospice benefit and a Medicare Part D drug plan. For purposes of administrative simplification, WellCare recommends either the Medicare Part A hospice benefit or the Medicare Part D plan should be responsible for the pharmacy component of the benefit.

Option 3: Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations

WellCare supports the permanent reauthorization of all Special Needs Plans (SNPs). SNPs are uniquely positioned to serve beneficiaries with complex health care needs by providing patient-centered, coordinated care that is not available in traditional Medicare FFS settings or MA Coordinated Care Plans. SNPs meet extensive data collection, reporting, and care management requirements. This includes development of an evidence-based model of care that is subject to rigorous CMS and National Committee for Quality Assurance (NCQA) review. SNPs must also meet additional care management requirements including providing appropriate networks of providers, initial and annual assessments of enrollees, and use of interdisciplinary teams.

Dual Eligible Special Needs Plans (D-SNPs) are a subset of SNPs that focus exclusively on serving individuals dually eligible for both Medicare and Medicaid. These plans tailor their care management models and benefit structures to meet the unique health care needs of dual eligible beneficiaries. D-SNPs are also held to specialized quality metrics by CMS, in addition to the metrics required of MA health plans. Given the significant value that D-SNPs provide to dual eligible beneficiaries, we are concerned by the recent trend of states limiting the number of D-SNP plans with which they contract to only the plans participating in the state's Medicaid program. WellCare encourages the Committee to require states to enter into *Medicare Improvements for Patients and Providers Act* (MIPAA) compliant D-SNP contracts with all CMS approved D-SNPs operating in their state. Doing so will promote beneficiary choice, ensure effective coordination of benefits, and prevent disruptions in care to vulnerable beneficiaries. Similarly, when a state is ready for full integration, all D-SNPs that meet CMS SNP qualifications and are ready, willing, and able to create the necessary delivery system to offer integrated Medicaid benefits should be offered a Fully Integrated Dual Eligible (FIDE) contract. The FIDE SNP contract has numerous advantages, namely leveraging a health information infrastructure to facilitate care coordination, providing capitated payment for all services offering significant savings potential for state and federal governments, simplifying care delivery for providers by providing a single integrated source for claims payment, and offering shared savings opportunities for providers through the delivery of quality care. However, we are concerned that many states are not yet prepared to move from a MIPAA-compliant D-SNP contract to a FIDE contract. As a result, we strongly oppose any requirement that would impair the ability of a plan to offer a non-FIDE D-SNP plan if a state makes the policy decision not to move to a FIDE model. Finally, many states contract with D-SNP plans to deliver some or all of a member's Medicaid benefits. Like any Medicaid managed care contract, the Medicaid benefits offered through D-SNP plans must be actuarially sound.

Option 4: Improving Care Management Services for Individuals with Multiple Chronic Conditions

As a plan focused on the needs of dually eligible beneficiaries and those who narrowly do not qualify, WellCare fully recognizes that individuals with multiple chronic conditions, including the vast majority of dual eligibles, have more complex care needs than non-dual eligible individuals and often require enhanced coordination of care efforts. Consistent with our previous comments, the patient criteria being considered by the Committee for the delivery of enhanced care management services should be

consistent across the entire Medicare program, and (if implemented) a new high-severity chronic code should apply to Medicare FFS as well as MA.

Numerous behavioral health conditions affect beneficiary well-being, and as such we recommend that the Committee expand the patient criteria for the potential new code from “Alzheimer’s or a related dementia” to include additional behavioral health diagnoses such as depression.

If implemented, all physicians who treat the qualifying condition(s) should be eligible to bill the new code for services related to the qualifying chronic condition. This would include behavioral health providers and any specialist.

We support temporarily instituting the code until such time as the Department of Health and Human Services can evaluate it based on appropriate provider, patient, and plan feedback.

Option 5: Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

A large percentage of our members have behavioral health conditions, which is intrinsically linked to their status as dual eligible beneficiaries. To assure the best possible care for our members we have built a model of care that fully integrates acute and behavioral health care. WellCare believes a fully integrated model is critically important in addressing the behavioral health needs of chronically ill beneficiaries. One of the most effective ways to improve the integration of care for individuals with a chronic disease is to include the Behavioral Health-Patient Centered Medical Home (BH-PCMH) model and its services as a covered benefit within the MA program. The BH-PCMH model emphasizes guiding beneficiaries to the most appropriate care setting as opposed to inpatient and emergency department utilization. BH-PCMH programs improve access through same day appointments, expanded hours (24/7 coverage), and new communication options between patients, their medical home, and practice staff (e.g. email or group visits). The combined physical and mental services available in this integrated setting represent an effective way to reach beneficiaries with chronic conditions.

Issue 3: Expanding Innovation and Technology

Option 1: Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

Increased flexibility of the benefit structure for an MA plan is integral to its success and that of its beneficiaries. All plans should be granted the type of flexibility described by the Committee, not just a subset of them, which would allow increased access to much-needed services for a larger number of beneficiaries. Using HCCs to identify which chronic diseases for which MA plan benefits would be tailored represents the most accurate process available.

We believe that in order to improve care for chronically ill beneficiaries, MA plans should be required to meet basic care benefits with the option of additional supplemental benefits directly associated with individual diagnoses. No care would be disrupted in this situation, and it would offer plans the flexibility to tailor specific services to individuals or populations in need along with the assumed cost savings of continuity/coordination of care. WellCare recommends piloting this approach initially to determine the administrative cost associated with varying benefit packages.

It is entirely possible for an individual to be diagnosed with a chronic condition at any point during a calendar year. WellCare asks the Committee to consider making a documented mid-year chronic condition diagnosis a life event, or event otherwise worthy of triggering a beneficiary's inclusion in an MA plan's supplemental benefit package described above. Early intervention would achieve the greatest success, making such a policy in the best interest of beneficiaries.

Option 2: Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

The application of supplemental benefits can assist plans in care coordination for beneficiaries so long as benefit design flexibility is granted for the plan. Standard benefits that should be included are those that improve access (transportation, reduced copayments, etc.) and increase the likelihood of adherence (medication dispensing equipment, cell phones with medication adherence reminders, reduced copayments on prescription products, etc.). We recommend that these benefits be included in the yearly bid process, however, to achieve appropriate rate adequacy.

At WellCare, we have extensive experience with dual eligible/low-socioeconomic status (SES) beneficiaries and how best to offer benefits that are specifically tailored to their needs. As such, we would encourage the Committee not to apply uniformity to any expansion of supplemental benefits. Doing so will allow plans to appropriately stratify risk based on each plan's individual population and connect beneficiaries with the services they need the most and will result in the best health outcomes at the lowest cost to them. The ability to do so should be available regardless of quality scores or populations.

Option 3: Increasing Convenience for Medicare Advantage Enrollees through Telehealth

WellCare supports health plan coverage of telehealth services for beneficiaries. Providing coverage for these services increases access to care and provides timely and effective delivery of health services to vulnerable populations such as individuals in rural areas, low-income individuals, and those with comorbidities. Congress should expand the allowed use of telehealth services beyond Medicare FFS and allow MA plans to include telehealth services in their benefit design and annual bid amount.

While we support beneficiary access to telehealth services under MA plan coverage, licensure presents a significant barrier to telehealth adoption. The federal government has the authority to establish national standards that regulate certain aspects of medical/health care practice. In order to allow Medicare beneficiaries to maximize the use of telehealth services, we encourage Congress to consider setting national standards to allow providers operating in the telehealth space to deliver care across state lines.

We encourage the Committee to waive any uniformity requirements related to covered telehealth benefits in order to allow plans to appropriately stratify according to risk within the population and offer targeted services that most directly address the health needs of beneficiaries.

Issue 4: Identifying the Chronically Ill Population and Ways to Improve Quality

Option 1: Ensuring Accurate Payment for Chronically Ill Beneficiaries

WellCare supports the changes to the CMS Hierarchical Conditions Category (HCC) Risk Adjustment Model proposed by CMS in October 2015. WellCare supports revision of the risk adjustment system to more appropriately compensate plans for serving full benefit dual eligible beneficiaries. The proposal represents a meaningful correction to a long-standing inequity in the risk adjustment model. Developing a risk adjustment model that includes separate community segments for specified populations allows for a more accurate prediction of the actual cost of caring for each individual subgroup.

WellCare recommends collecting data on how changes to the model will affect costs for full and partial dual eligible beneficiaries, and waiting for results from the final phase-in before determining any changes in predicted costs associated with the interaction between behavioral/mental health conditions with physical health conditions. WellCare supports the evaluation of using 2 years of data to determine the impact on risk scores and the development of an actuarial opinion from the Chief Actuary of CMS. We encourage CMS to include in this report separate risk scores for year 1 and year 2, as well as the methodology and the normalization factor used to calculate the risk score using 2 years of data.

Additionally, the HCC study of functional status proposed by the working group should also investigate the barriers to care presented for individuals of low SES (i.e. transportation challenges, social supports, residence in a high crime area and health professional shortage areas, etc.). These factors have a significant impact on beneficiary health status, and thus the risk score associated with them.

Option 3: Developing Quality Measures for Chronic Conditions

Quality measurement that focuses on health processes and outcomes is integral to accurately assessing the quality of care delivered to the beneficiary. WellCare encourages the Committee to look to currently endorsed National Quality Forum (NQF) measures across various populations and patient settings that address the areas identified by the Committee, such as care coordination, hospice and end-of-life care, and community level measures, and work with measure promulgators and stakeholders to adjust measures to best meet the needs of the target population. With over one thousand measures currently endorsed, we recommend that legislators utilize existing measures and align the various measure sets in order to achieve consistency of application rather than creating new measures.

Additionally, WellCare believes there should not be separate Medicare-Medicaid Plan (MMP) and D-SNP measure sets, as D-SNPs and MMPs are closely related in terms of measurement criteria. As such, WellCare suggests that the Committee should utilize the current duals measure set that includes supplemental Long-Term Services and Support (LTSS) measures for plans (e.g. a FIDE plan or MMP includes LTSS services).

Issue 5: Empowering Individuals & Caregivers in Care Delivery

Option 1: Encouraging Beneficiary Use of Chronic Care Management Services

We understand that cost is a chief concern for the Committee and for many Medicare beneficiaries. In fact, one of the strengths of the Medicare Advantage program is plans' ability to help contain costs while delivering high quality care. The working group proposes waiving cost sharing in order to bolster the chronic care code take up rate. The Committee notes how CMS reimburses an average of \$42 for the chronic care management (CCM) code, while beneficiaries are responsible for a 10 percent copayment of \$8. WellCare supports alleviating the financial burden that could prevent beneficiaries from receiving the care they need so long as reimbursement rates are appropriately considered. Waiving the copay can be especially helpful to low-income beneficiaries who struggle with balancing the costs of basic life necessities against health care expenditures. Many of our plans already offer no or low copays that encourage beneficiaries to utilize the services we offer without the requirement to do so.

A key component of plans' ability to help beneficiaries lower their costs and thus increase access involves benefit uniformity among all plans. By allowing plans to stratify the population they serve based on risk factors, plans can focus variable out of pocket costs on members with specific health conditions, specific social barriers, or to direct beneficiaries to specific centers of excellence. We encourage the Committee to consider waiving uniformity to allow plans to best tailor their coverage and service to the specific needs of the populations they serve.

Option 2: Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious of Life-Threatening Illness

Given the severity of many diseases considered under this category WellCare believes that the scope of this benefit should not be limited to a one-time visit. These are critical discussions and should be expanded to cover additional visits as necessary. A single planning visit is often insufficient to appropriately prepare for a major illness that threatens an individual's life, and thus additional visits should be included and covered.

WellCare additionally recommends that the Committee clarify the difference between this recommendation and end of life/care management coding discussed in other options within the document.

Issue 6: Other Policies to Improve Care for the Chronically Ill

Option 2: Study on Medication Synchronization

WellCare recognizes medication synchronization as one tool that may improve medication adherence. Prescription drug therapy provides a tremendous value to the overall healthcare system and that value is only realized when medication therapies are taken by patients as prescribed. WellCare supports continued industry development and rollout of medication synchronization programs and believes that best practices currently being developed will benefit patients and payers.

Medication synchronization programs have improved medication adherence, when coordinated between the pharmacy, the patient and the payer (health plan/pharmacy benefits manager [PBM]). Legislation has been proposed that explicitly excludes health plans from the decision making process involved in implementing a medication synchronization program. Such bills fail to recognize that the design and cost implications of a medication synchronization program must remain within the purview of the contracting entities.

WellCare supports continued development and implementation of collaborative medication synchronization programs that include patients, prescribers, and plans. A study to investigate the coordination prescription drug dispensation and barriers to coordination would be welcomed.

Additional Comments

WellCare encourages the Committee to include recommendations related to the CMS MA Star Ratings program and its intersection with chronic care beneficiaries. A significant proportion of MA beneficiaries who are eligible for both Medicare and Medicaid as well as other low-income MA beneficiaries have multiple chronic conditions.

There is a large body of third party and impartial research that supports the finding that individuals with low socio-economic status (SES) have poorer health outcomes than individuals with higher SES. In addition to being more likely to receive delayed diagnoses and treatment, individuals with low SES are more likely to experience social factors that complicate their care such as limited access to financial and community resources, lower levels of income and educational attainment, and worse health outcomes. This population tends to have greater chronic care needs, and requires interventions of greater frequency and intensity in order to show health improvements.

One example that illustrates how dual eligible beneficiaries/ low-SES beneficiaries with chronic conditions require additional interventions in order to improve health outcomes is the challenge of medication adherence. More than one quarter of aged dual eligible beneficiaries have the five most frequent chronic conditions— ischemic heart disease, heart failure, Alzheimer’s and related conditions, diabetes, and rheumatoid arthritis or osteoarthritis. Many dual eligible beneficiaries have three or more chronic conditions.¹ The greater the number of chronic conditions a beneficiary faces, the greater the number of medications the beneficiary is typically prescribed.² Even for a high-SES beneficiary, adherence to multiple medications can present a challenge.

CMS uses a Star Ratings program to provide Medicare beneficiaries with additional information about the performance of plans offered in their area. All Medicare Advantage and Part D plans are rated on a 1 to 5 star scale. The scores are based on performance measures that are derived from plan and beneficiary information collected in three surveys – HEDIS, CAHPS, and HOS – and administrative data.

¹ MedPAC. Report to the Congress: Aligning Incentives in Medicare, Coordinating the Care of Dual Eligible Beneficiaries, June 2010

² CMS. Medicare Current Beneficiary Survey, 2012. Characteristics and Perceptions of the Medicare Population, Tables 8.3, 8.5, and 8.7. Dual eligible data are collected from the “Medicaid buy-ins” column. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html?DLPage=1&DLSort=0&DLSortDir=descending>.

A subset of these measures evaluates a beneficiary's ability to adhere to his/her prescribed medications. Plans with a high proportion of low-SES, chronic care enrollees are at a substantial disadvantage on medication adherence measures, since low-SES is correlated with poor medication adherence. In fact, a high proportion of low-SES enrollment is a strong predictor of low plan performance on quality measures overall. Plans choosing to serve Medicare beneficiaries of low-SES, including dual eligibles, are penalized under the current Star Ratings system because it does not account for the full impact that low-SES factors have upon plan performance. For this reason, WellCare supports changes to the Star Ratings methodology to account for the added challenges of serving low-SES MA beneficiaries with substantial chronic care needs.

In September 2014, CMS issued a Request for Information (RFI) on the differences in Medicare Advantage (MA) and Part D star rating measurements for dual eligible versus non-dual eligible enrollees. Numerous plans, including WellCare, responded with supporting data to demonstrate the impact of dual eligible members on plan performance. In response to the RFI submissions, CMS offered in the 2016 Draft Call Letter a proposal to reweight certain measures for which there appeared to be evidence of an impact of SES on plan performance. This proposal was withdrawn in the Final Call Letter. In 2015 CMS commissioned a study completed by the RAND Corporation which examined the impact of dual status and disability status on plan performance under the stars methodology. Following the RAND study, CMS released its annual *Enhancements to the 2017 Star Ratings and Beyond* document in November 2015, which included two unique proposed solutions to correct the disparity tied to serving dual eligible beneficiaries. Neither of these proposals can be modeled based on the limited amount of information released by the agency, making it difficult to determine the impact of either proposal.

We encourage the Committee to use the opportunity with its work on chronic care to continue to look at the effect of SES on stars performance and provide policy solutions that appropriately account for the difficulty faced by plans serving dual eligible members with high numbers of chronic conditions.

We recommend that Congress require CMS to address this bias in the quality measurement methodology in order to encourage, rather than penalize plans that serve the neediest Medicare beneficiaries.

Sincerely,

A handwritten signature in black ink, appearing to read "Elizabeth Cahn Goodman", enclosed in a thin black rectangular border.

Elizabeth Cahn Goodman