January 26, 2016

Submitted electronically via chronic_care@finance.senate.gov

Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Chronic Care Working Group Policy Options Document, December 2015

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

Aetna is one of the nation's leading diversified health benefit companies, providing members with resources to enable better informed decisions about their health. We are pleased to respond to the Senate Finance Committee's recent request for comments on the Chronic Care Working Group's Policy Options to improve care coordination in the Medicare program.

Aetna is committed to early care coordination for Medicare beneficiaries with chronic conditions, and we strongly support the Committee's focus on improving health outcomes for those with chronic conditions. We recommend that with respect to Medicare Advantage plans, the working group should:

- Permit supplemental benefits,
- Integrate behavioral health care,
- Encourage the provision of telehealth,
- Study whether the use of functional status would improve the accuracy of risk adjustment, and
- Keeping the hospice benefit in traditional Medicare in order to ensure maximum beneficiary choice in choosing a hospice provider at end of life. In the alternative, CMS could test a model that would give MA plans the ability to provide curative care to plan enrollees concurrently with the hospice benefit (while keeping the hospice benefit in FFS) and liberalize the eligibility requirement of a 6 months prognosis to 12 months.

We also recommend the working group consider supporting H.R. 3244: Providing Innovative Care for Complex Cases Demonstration Act of 2015

This bipartisan legislation introduced in the House last summer establishes a pilot program that would test a new and innovative approach to improving care for Medicare's sickest and most chronically ill beneficiaries. This pilot program would improve quality by allowing only the most highly qualified Medicare Advantage plans and Accountable Care Organizations to deliver integrated, coordinated care to the costliest 10 percent of Medicare beneficiaries, who account for nearly 60 percent of FFS

spending, at a lower cost to the federal government than the current fee-for-service (FFS) system.

Testing the model outlined in this legislation would allow CMS to accelerate efforts to improve care for Medicare's most chronically ill patients by adopting many of the policies proposed by the Working Group, including the ability to provide beneficiaries with more benefits, reduced cost sharing and a dedicated health professional to help them navigate the health care system so they get the right care at the right time.

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We appreciate the opportunity to submit these comments on the chronic care working group's policy options document.

If you have additional questions, please feel free to contact me.

Sincerely,

Steven B. Kelmar
Executive Vice President, Corporate Affairs

Addendum

Enclosure

Addendum: Aetna Letter to the Chronic Care Working Group Policy Options

1. **Comments on:**
   - **Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees**
   - **Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees**

The chronic care working group is considering giving Medicare Advantage (MA) plans the flexibility to provide tailored benefits that would reasonably be expected to improve the care and/or prevent the progression of the chronic conditions affecting MA enrollees. Specifically, the chronic care working group is considering allowing MA plans to offer (1) additional supplemental benefits not currently allowed, (2) reductions in cost sharing for items/services to treat the chronic condition, (3) adjustments to provider networks to allow more providers and non-clinical providers to treat the chronic condition, and (4) care improvement or wellness programs tailored to the chronic condition.

Aetna supports the recommendation to allow MA plans to specifically tailor their benefit package to meet the needs of chronically ill individuals. Allowing plan flexibility is critical to the success of this proposal: flexibility allows MA plans to improve clinical outcomes, slow the rate of disease progression, minimize financial and other barriers to those most in need, and offer access to services that have been not been traditionally allowed but that may improve quality and lower cost (e.g., non-emergent transportation or healthy meals).

We note that the working group's proposal is similar to the high-cost beneficiary approach that Aetna offered last summer, which would have created a pilot program that would provide enhanced benefits not currently covered under the Medicare program, including in-home personal care, transportation, and meal services, while reducing or eliminating cost sharing to remove barriers and improve health outcomes. Aetna's high-cost beneficiary program would also establish high-quality provider networks that ensure patients are receiving integrated coordinated care.

As we initially proposed, it is important that MA plans be permitted to provide a wide variety of supplemental benefits. These benefits should address medical, psycho-social, or other barriers to effective treatment and should not be limited to medical interventions. For example exercise, wellness, nutrition, and transportation benefits are valuable to ensuring effective treatment and preventing the progression of chronic disease. Similarly, we suggest explicitly incorporating remote access technologies (including, but not limited to telehealth) as a supplemental benefit that may be provided by MA plans to those with chronic conditions. Remote access

technologies, for example, decision support tools (such as applications and web portals) may help cheaply and effectively assist individuals manage their chronic condition and assist their medical team in tracking compliance with treatment regimens.

Another key component to a successful supplemental benefits program is that MA plans be permitted to identify the beneficiaries most in need, and identify the supplemental benefits most critical to ensuring successful treatment for that beneficiary. In other words, MA plans must have the discretion to provide benefits where the benefits are most appropriate and have most value—there should not be a general mandate to provide the supplemental benefit to all beneficiaries suffering from the same chronic condition. For example, if a case manager identifies transportation as a significant barrier to care, the case manager should be able to provide a transportation supplemental benefit to that beneficiary. The plan should not be required to provide transportation to all beneficiaries that suffer from the same chronic condition.

Finally, we suggest that this value-based insurance design should be based on prevalent conditions in the older adult population using standardized clinical definitions and codes to ensure the right beneficiaries are offered the tailored benefits.

Recommendations:

- Give MA plans the flexibility to establish benefit structures designed for certain chronic conditions.
- Identify the chronic conditions by reference to CMS' current data: for example, select the top 20 most prevalent conditions, using standardized clinical definitions and codes, suffered by Medicare beneficiaries.
- Do not limit the program by geography; the program should be available nationwide.
- Allow MA plans the flexibility and discretion to provide supplemental benefits to those beneficiaries with the most need, and those beneficiaries that would benefit most.
- Support remote access technologies as a supplemental benefit.

2. Comments on Providing MA Enrollees with Hospice Benefits

The chronic care working group is considering requiring MA plans to offer the hospice benefit provided under traditional Medicare. Aetna has had over a decade-long commitment to provide interdisciplinary care team approaches to people with advanced illness through its Compassionate Care Program. This proven program has improved quality of care, allowed people and caregivers to receive care in the setting most aligned to their wishes, and resulted in significant quality improvements and reductions in avoidable hospitalizations. Access to high quality hospice care has not been a barrier to care in the markets Aetna serves.

As a result, Aetna does not support the requirement for MA plans to offer the hospice benefit, which is currently offered under traditional Medicare and provides beneficiaries a wide range of choices when selecting a hospice at the end of life. Aetna continues to collaborate with hospice providers, even when its members elect the hospice benefit. We have not seen fragmentation of care when members transition to hospice, as the same requirements for clinical information exchange exist during the transition from any one provider to another. We also do not believe that the resources required to contract hospices and create a de novo network is an efficient use of initial and ongoing health plan staff. Finally, the availability of adequate individual hospice quality measures is limited, which precludes the ability to create a fully-informed, new network using an evidence-based approach and therefore would necessitate a blanket re-creation of the existing Medicare-approved hospices covered by Original Medicare.

In the alternative, CMS could test a Hospice model that would that would give MA and MA-Prescription Drug (MA-PD) plans the ability to provide curative care to plan enrollees concurrently with the hospice benefit (while keeping the hospice benefit in FFS) and liberalize the eligibility requirement of a 6 months prognosis to 12 months. As part of a model, we recommend CMS monitor Hospice length of stay; impact on acute, intensive care unit and emergency room utilization; impact on medical cost; and member and family satisfaction (through FERC or similar survey instrument). We also recommend that a model include the study of utilization of all services in the hospice population, particularly those services deemed "curative."

Recommendations:

- Keeping the hospice benefit in traditional Medicare in order to ensure maximum beneficiary choice in choosing a hospice provider at end of life.

- In the alternative, CMS could test a model that would give MA and MA-Prescription Drug plans the ability to provide curative care to plan enrollees concurrently with the hospice benefit (while keeping the hospice benefit in FFS) and liberalize the eligibility requirement of a 6 months prognosis to 12 months.

3. Comments on Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

The working group is considering developing policies that improve the integration of care for individuals with a chronic disease combined with a behavioral health disorder. Aetna strongly supports integration of behavioral health services with primary care services. In our experience, however, one significant challenge to the ability to integrate needed mental health services is the availability of such services. Put simply, the availability of behavioral health resources and expertise in the primary care setting is limited in many communities, and insufficient access to high quality clinicians precludes creation of robust integration and to continuity of behavioral health care, which is essential. We would encourage the working group to work with CMS to further encourage and solicit integrated, high-quality community mental health resources, particularly in underserved communities.

Recommendation:

- Develop and encourage high-quality community mental health resources.

4. Comments on:

- **Increasing Convenience for Medicare Advantage Enrollees through Telehealth**
- **Providing ACOs the Ability to Expand Use of Telehealth**
- **Expanding Use of Telehealth for Individuals with Stroke**

The working group offers several proposals with respect to telehealth services, including expanding Medicare's qualified originating site definition to include free-standing renal dialysis facilities located in any geographic area so that beneficiaries could meet with providers via telehealth, permitting MA plans to include certain telehealth services in its annual bid amount, modifying the requirements for reimbursement for telehealth services provided by ACOs, and eliminating Medicare's originating site geographic restriction for the narrow purpose of promptly identifying and diagnosing strokes via telehealth services.

Aetna strongly supports allowing MA plans to include telehealth services coverage in their bids. Allowing payers and providers to use telehealth as another option in the

care delivery model makes sense, allowing care to be provided efficiently, at high quality, and with improved access for beneficiaries. Similarly, Aetna supports modifying the requirements for reimbursement of telehealth services for ACOs.

In contrast, Aetna does not support the working group's proposals to expand access to telehealth only for use in identifying and diagnosing stroke. This proposal imposes unnecessary specificity; limiting a proposal to only stroke diagnoses deprives other beneficiaries with similarly high severity, time-sensitive conditions from the same technology benefits. Instead, Aetna strongly supports expanding the use of telehealth services without regard to geography or potential diagnosis to ensure that all Medicare beneficiaries are able to access quality, efficient and convenient telehealth services as appropriate.

Recommendations:

- Permit MA plans to include telehealth services in their bids.
- Modify the requirements for reimbursement of telehealth services for ACOs to encourage greater availability of telehealth services.
- Expand the use of reimbursable telehealth services by eliminating any geographic- or condition-dependent criteria.

5. Comments on Ensuring Accurate Payment for Chronically Ill Individuals

As the working group notes in its policy options document, payments made to MA plans are risk adjusted using CMS' HCC Risk Adjustment model that takes into account the severity of a beneficiary's illness, as well as demographic and other effects. The working group is considering a study to examine whether the use of functional status (activities of daily living or other means) would improve the accuracy of risk-adjusted payments.

Recommendation:

- Move forward with a study to examine whether the use of functional status, as measured by activities of daily living to determine if this would improve the accuracy of risk adjustment payments.