David Schwartz
Head of Global Policy
Cigna Federal Affairs

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VIA ELECTRONIC SUBMISSION TO chronic_care@finance.senate.gov

601 Pennsylvania Avenue, NW
Suite 835, South Building
Washington, DC 20004
(202) 719-6499
David.Schwartz@Cigna.com

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

Re: Bipartisan Chronic Care Working Group Policy Options Document

Dear Senators Isakson and Warner:

Cigna welcomes the opportunity to respond to the Senate Finance Committee Chronic Care Working Group (Working Group) Policy Options Document (released December, 2015). We appreciate the Committee's efforts to improve the health and well-being of the Medicare population, and believe that our experience in bringing high quality care coordination, management, and health outcomes to almost 500,000 enrollees in our Medicare Advantage (MA) plans, many of whom have one or more chronic conditions, makes our insights on how to bring these ideas to beneficiaries in the fee-for-service (FFS) program especially relevant. We support many of the options for improving care for the chronically ill outlined in the document, and have suggestions for the Working Group as it continues to develop its ideas.

In the comments that follow we offer feedback on specific proposals included in the options document. There is one proposal that we were disappointed was not included: a change to the Star Quality Rating System to account for underlying differences in the socioeconomic status of plan populations. Ensuring that MA plans are able to serve the chronically ill requires recognition of the unique barriers that plans face when they serve these members, and adjusting the existing payment and quality rating systems to account for added costs and barriers that come with serving the sickest and most vulnerable beneficiaries.

Both our own experience and external research clearly show that the burden of chronic illness falls heavily on beneficiaries who are dual-eligibles – those who qualify for both Medicare and Medicaid. Recent data suggest that about one third of dual-eligibles have diabetes, more than half have high blood pressure, and up to a third have chronic heart disease. Chronic cognitive and behavioral health conditions also affect the dual-eligible population: 23 percent of dual-eligibles age 65 and older suffer from Alzheimer's disease or related dementia, 20 percent suffer from depression, and 11 percent have anxiety disorders (Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, January 2015). As these statistics demonstrate, the care management that MA provides is especially critical for dual-eligibles.

Research from the Medicare Payment Advisory Commission, the National Quality Forum, the Institute of Medicine, the Centers for Medicare & Medicaid Services, and numerous independent researchers shows that serving a disproportionate share of dual-eligible members leads to lower Star ratings independent of the quality of care delivered by the plan. In our earlier comments to the Working Group, we urged Congress to implement a

short-term adjustment to Star ratings that would adjust for the ratings disparity due to differences in socioeconomic status of a plan's members. The need for such an adjustment continues, and we once again urge the Working Group to include a provision to fix the Star ratings disparity in any chronic care legislation. Without an adjustment, the millions of dual-eligible members who rely on MA to provide chronic care management risk losing access to benefits and services that help them maintain and improve their health.

Providing MA Enrollees with Hospice Benefits: Cigna supports the proposal to incorporate Medicare's hospice benefit into MA. At an especially difficult time, enrollees who elect the hospice benefit currently face difficultly navigating and coordinating hospice benefits under traditional Medicare along with non-hospice benefits that continue to be provided by the MA plan. We would caution that MA plans need sufficient time to establish provider networks and incorporate the necessary services into plan packages.

Allowing End Stage Renal Disease (ESRD) Beneficiaries to Choose an MA Plan: Cigna does not support the proposal to allow beneficiaries with ESRD regardless of when the condition began, to enroll in MA. We believe that the current structure of providing care and benefits to ESRD patients under the traditional Medicare program together with ESRD-focused special needs plans serves beneficiaries. Regular MA plans are not best suited to incorporate the cost management and utilization needs of these very high cost beneficiaries into broader plans. In addition, our experience shows that the current risk adjusted payment for patients with ESRD does not compensate adequately for the costs of treating these members. If a policy to allow all Medicare beneficiaries with ESRD to enroll in MA is pursued, the current payment model must be modified to sufficiently account for the very high costs incurred by these patients.

Providing Continued Access to MA Special Needs Plans (SNPs) for Vulnerable Populations: Cigna supports the proposal to provide for a long-term or permanent authorization for SNPs that serve institutionalized enrollees (I-SNPs), enrollees with chronic illnesses (C-SNPs), or those who are dually-eligible for Medicare and Medicaid (D-SNPs). SNPs are best able to address multiple, complex, and ongoing chronic care needs of frail, disabled, and chronically-ill beneficiaries — the most costly and fastest-growing segment of the Medicare population. Granting permanent authorization to SNPs would provide stability for beneficiaries and their families by ensuring that the SNPs they chose will not sunset; enable Congress to build upon plans that are grounded in the principles of chronic illness care for high-risk/high-need persons; and provide greater certainty to States seeking to integrate Medicaid and Medicare for dual-eligible beneficiaries through D-SNPs. Temporary extensions of D-SNP authority have created uncertainty for many of the States that want to integrate Medicare and Medicaid via D-SNPs. Giving permanent authority for SNPs is the best way Congress can give certainty to States to enable them to plan ahead to use the D-SNP platform to integrate care for dual-eligibles. Finally, permanent authorization would encourage States, plans, and providers to make needed long-term investments in chronic care systems that are most important to ensuring Medicare's and Medicaid's long-term financial viability.

Adapting Benefits to Meet the Needs of Chronically Ill MA Enrollees: Cigna supports offering greater flexibility to MA plans to design benefits that improve care for beneficiaries with specific illnesses or risk factors. At the same time, we caution that moving from concept to concrete value based insurance design (VBID) is highly complex, and may be difficult to implement in a way that produces savings in a diverse Medicare population. For this reason, we would recommend that VBID be introduced and allowed to operate along with the current C-SNP model, rather than as a replacement for C-SNPs. C-SNPs currently bring specific benefits, services, and disease management to chronically ill MA beneficiaries. Ending the C-SNP program before plans, patients, and the Medicare program have experience with VBID would threaten care and access for these enrollees. Over time, as MA plans gain greater experience with designing and implementing VBID in a way that improves care

for chronically ill members in cost-effective way, the appropriate role of C-SNPs and VBID models will become clear.

Cigna believes that all MA plans should be allowed the flexibility to tailor benefits that improve care for specific enrollee populations, and we do not recommend that the Working Group restrict VBID based on plan quality. Doing so would likely deny access to VBID for exactly those beneficiaries who are most in need of benefits designed to improve care quality and reduce barriers to care for chronic illnesses. Plans that struggle to achieve high Star ratings may use VBID models to improve care for members with higher need, leading to better health outcomes and higher quality ratings.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill MA Enrollees: Cigna also supports expanding MA plans' ability to offer supplemental benefits beyond those currently allowed in order to improve care for chronically ill members. Greater flexibility in benefit design offers the opportunity to target resources more precisely to those services that demonstrate the most benefit in terms of health outcomes and quality for our members. At the same time, we would caution that requiring that any new supplemental benefits be paid by plan rebate dollars would require plans to make trade-offs between existing supplemental benefits that members value and expect, and potential new benefits. We would recommend that the Working Group evaluate the impact that supplemental benefits may have on overall health care costs and outcomes, and consider ways to incorporate this impact in valuations of MA spending and reimbursement.

Increasing Convenience for MA Enrollees through Telehealth: Cigna supports expanding telehealth services for MA enrollees beyond those currently permitted in the traditional Medicare program. One major impediment to broader use of telehealth in MA is the wide variation in state level requirements that make it difficult for MA plans to design and operate telehealth programs and policies that meet widely-varying state regulations. We urge Congress to establish a single set of consistent regulations around the provision of telehealth services for all Medicare beneficiaries, regardless of in which state they live. These rules would allow MA plans and providers to move forward with designing and implementing telehealth programs that bring greater access, higher quality care, and more advanced care to beneficiaries regardless of geographic location.

Ensuring Accurate Payment for Chronically Ill Individuals: Cigna supports a risk adjustment model for MA payments that is accurate and pays MA plans appropriately for the costs of providing care to MA members. With that as a framework, we offer additional comments on specific components of the proposal to modify the existing risk adjustment model:

- Total number of chronic conditions: We support the proposal to include the total number of chronic conditions a beneficiary has in the risk adjustment model. Having more than one or two chronic conditions may increase the complexity of providing appropriate care to a member that is not reflected in individual condition factors already in the risk adjustment model.
- Use of more than one year of data to establish risk score: We support the proposal, and would recommend that MA risk scores be calculated using two years of data, as the Medicare Payment Advisory Commission suggests. Cigna believes that using two years of data would bring greater accuracy to the model, thereby reducing errors in risk coding.
- Interactions between behavioral/mental health conditions with physical health conditions: We support this proposed change.
- Difference in costs due to eligibility pathways: We ask that the Working Group provide more information about this proposed change to allow stakeholders to better understand and consider any potential impact.

- Use of functional status: We support including a functional status factor in the risk adjustment model, as we believe that functional status is related to cost. That said, we recognize the difficulty in measuring functional status for all beneficiaries.

Developing Quality Measures for Chronic Conditions: Cigna supports development of quality measures for chronic conditions. Cigna encourages the Working Group to develop meaningful quality metrics that measure health outcomes and patient engagement for members with chronic conditions. For example, member, family, and caregiver engagement in care team meetings is important for treating chronic conditions; unfortunately, members and their caregivers rarely attend these meetings. We would suggest consideration of alternate metrics around this need for engagement such as frequency of primary care physician (PCP) visits, as these providers are the primary developers and drivers of the care plan.

In the same way that defining appropriate quality metrics for medical management of patients with multiple chronic conditions is complex, so too is creating quality metrics for patients with multiple chronic conditions . We encourage development of metrics that create a large enough denominator to apply statistical significance rather than developing metrics that study a very small subset of the population. Additional consideration around these complex metrics would be development of metrics that reflect coordination of care between the multiple entities (such as PCP, specialist and health plan) in achieving positive outcomes.

Study on Medication Synchronization: Cigna supports medication synchronization programs, and supports a study to identify best practices, barriers to implementation, and health outcomes for patients who use medication synchronization programs. We have implemented a medication synchronization program within some Cigna-HealthSpring pharmacies that has been well received by patients. Patients can choose either a 30 or 90 day program and instead of making multiple trips to the pharmacy for multiple medications they are able to make one trip. This improves patient safety, pharmacist education, and overall quality of care by improving medication adherence. Medication synchronization programs are moving into the retail pharmacy space as well, making synchronization more of an option for patients and health plans seeking and improved experience. We do caution that any study should consider the needs of patients with limited financial resources, who may need to spread out the acquisition of medications to accommodate their overall financial requirements.

In summary, Cigna supports the work of the Senate Finance Committee Chronic Care Working Group to improve chronic care for all Medicare beneficiaries. We believe that many of the proposals included in the policy options document would contribute to better care for the chronically ill, and look forward to working with the Senate Finance Committee and CMS to bring better care to the Medicare population. We urge the Working Group to continue working on proposals that improve care for chronically ill and vulnerable populations, and include changes to the Star ratings that account for differences in socioeconomic status of plan populations to ensure that all chronically ill beneficiaries have access to high quality care and better health.

Thank you for your consideration of these comments.

Respectfully,

David Schwartz