The Honorable Orrin Hatch
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
U.S. Senate
Washington, DC 20510

The Honorable Johnny Isakson
U.S. Senate
Washington, DC 20510

The Honorable Mark Warner
U.S. Senate
Washington, DC 20510

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

SCAN Health Plan (SCAN) applauds the Senate Finance Committee and the Bipartisan Chronic Care Working Group for releasing the Bipartisan Policy Options Document, and we are pleased to see many of SCAN's recommendations included within the proposals being discussed by the Committee. We welcome the opportunity to provide additional feedback on the policies put forward by the working group.

SCAN is a not-for-profit health plan that serves seniors through Medicare Advantage (MA) plans, including all forms of special needs plans (SNPs). Approximately 170,000 Medicare beneficiaries are enrolled in SCAN's MA plans in California, making it the fourth largest not-for-profit MAPD plan in the country. Since 1985, SCAN has specialized in providing comprehensive, high-quality care to the most vulnerable Medicare beneficiaries – those who live with multiple chronic conditions, who are eligible for nursing home care, who experience difficulty performing activities of daily living, and who may also qualify for Medicaid.

More than 27% of SCAN's Medicare beneficiaries have diabetes, and another 27% have Chronic Kidney Disease (CKD). Because of the complex nature of our members' health conditions, SCAN has created a care management model that emphasizes prevention and early intervention, with a keen focus on medication management. Highly trained care teams address the complex needs of the chronically ill population, and each program is coordinated with others to ensure safe and effective care transitions between all levels of care and providers.

SCAN is pleased to share additional comments on the policy proposals the Working Group has put forward. We believe there is a tremendous opportunity to help individuals with chronic conditions to achieve improved health and independence.

Expanding the Independence at Home Model of Care – The Chronic Care Working Group (CCWG) is considering expanding the current Independence at Home (IAH) demonstration into a permanent, nationwide program. The working group is also contemplating certain modifications to the program, including the use of hierarchical condition categories (HCC) risk scores to identify complex chronic care beneficiaries for inclusion in IAH instead of requiring that the individual undergo a non-elective hospitalization within 12 months of his or her IAH program participation.

SCAN is encouraged by the first year results of the IAH demonstration and is supportive of expanding the demonstration into a permanent, nationwide program. SCAN places an emphasis on ensuring beneficiaries are receiving the right care, in the right setting, at the right time, and we believe the goals of the IAH demo are in tandem with our mission.

In response to the working group's request for input on issues to be addressed through this policy option, we believe that finding complex patients through only HCC risk scores may not be adequate in a fee-for-service (FFS) population. We, therefore, recommend including additional metrics – such as physician referrals, hospitalizations, or a combination of Health Risk Assessments and HCCs – to identify patients with Activities of Daily Living (ADL) deficits.

Expanding Access to Home Hemodialysis Therapy – The Chronic Care Working Group is considering expanding Medicare's qualified originating site definition to include free-standing renal dialysis facilities located in any geographic area. The working group has solicited feedback on whether: (1) any safeguards should be in place for beneficiaries who are undergoing home dialysis therapy and would be utilizing their expanded access to monthly visits via telehealth; and (2) the home also should be considered an originating site for this limited purpose.

As described in the Policy Options Document, we support designating a beneficiary's home as an originating site when the individual is evaluated by their provider in the home setting. In this circumstance, we believe it is appropriate to require one face-to-face visit with a provider every six months.

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. SCAN supports incorporating the Medicare hospice benefit into the MA program, provided the hospice services meet rigorous quality standards. Carving in the benefit will reduce fragmentation of care and provide beneficiaries with access to integrated and coordinated care services during the most vulnerable phase of life. Ensuring quality care is delivered to beneficiaries in hospice is critical, and we recommend including the following plan-driven quality measures: days in hospice after enrollment, members who died in hospice setting, pain/symptom control, member satisfaction, and caregiver satisfaction. MA

organizations should also be allowed the flexibility to offer the benefit by an MA plan itself or through a contract with accredited/certified hospice providers.

For some individuals, the concept of hospice is difficult to absorb, and there may be a preference for an integration of hospice and palliative care. We believe it is critical to encourage flexibility among hospice and palliative care providers and incent the development of a coordinated care plan that address all aspects of care needed during the end of life stage.

In order to improve the Medicare hospice benefit, SCAN is also supportive of providing curative care to beneficiaries receiving hospice services, in combination with extending the benefit to individuals with life expectancies of up to 12 months.

Allowing End Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan – The Chronic Care Working Group is considering a policy that would allow all beneficiaries with end stage renal disease (ESRD), no matter when the condition began, to enroll in a MA plan. SCAN supports this policy option. In order to assist individuals in choosing the most appropriate health plan for their needs, we recommend sharing a few quality measures with beneficiaries, including a plan's 5-star Rating, kidney transplant rate, United States Renal Disease System (USRDS) quality measures and overall member satisfaction.

Providing Continued Access to MA SNPs for Vulnerable Populations – The Chronic Care Working Group is considering either a long-term extension or a permanent authorization of all special needs plans. Since 2006, SNPs have proven their value in organizing care for beneficiaries with health challenges, including chronic disease, and SCAN believes that Congress should affirm this record and make all forms of SNPs permanent.

In particular, chronic condition SNPs (C-SNPs) allow beneficiaries access to care plans and provider networks designed especially for their health conditions. Beneficiaries are free to enroll or change plans year round as chronic conditions develop or worsen.

The chronic care working group is also considering requiring SNPs that serve dual eligibles (D-SNPs) to fully integrate Medicare and Medicaid services. SCAN is a fully-integrated dual eligible special needs plan (FIDE-SNP) in multiple counties in California and recognizes the benefits of fully integrating the Medicare and Medicaid programs. We support this proposal. However, it is important to recognize that limitations and barriers exist within some states. Requiring D-SNPs to offer fully integrated Medicare and Medicaid services to their enrollees in only a short time frame and without adequate support or resources could inadvertently restrict beneficiary access to D-SNP products in some states. SCAN, therefore, supports a phased-in approach to this policy option, in order to help states and health plans transition from the D-SNP model to the FIDE-SNP model without impact beneficiary access.

Improving Care Management Services for Individuals with Multiple Chronic Conditions – The Chronic Care Working Group is considering establishing a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule. SCAN

recommends that individuals eligible to receive services under this code should have at least one severe chronic condition, which could include a behavioral health condition, and may include an activity of daily living deficit, which would make their condition more complex. We also believe that, in order for the proposed high severity chronic care management code to be appropriate and effective, there needs to be documentation of a care plan being generated by an interdisciplinary team including the primary care physician, case manager, and social workers.

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 and a behavioral health disorder. As the working group is aware, data sharing and privacy rules related to mental health visits are the largest barrier to care coordination between physical health providers and mental health providers. While this is a difficult issue to navigate, we believe that sharing mental health visit data with other providers to initiate care coordination models would benefit the affected population, just as data sharing has improved care for other populations.

When evaluating ways to improve behavioral health services for chronically ill beneficiaries, SCAN recommends considering coverage of transportation, group psychotherapy, and telehealth services. As the Committee continues to look at this issue, we recommend considering IMPACT, an evidence-based depression care model that may provide insight into the best way to effectively deliver care in an integrated team-based setting[1]. We also recommend exploring incentives or models of care that co-locate physical and behavioral health to make it easier for beneficiaries to have all of their needs met in one location.

Additionally, SCAN supports reimbursement through a behavioral health code for integration of behavioral health and chronic conditions, similar to what is being done for chronic care. This could be implemented by the primary care team as they incorporate behavioral health recommendations into the patient's care plan.

Adapting Benefits to Meet the Needs of Chronically Ill MA Enrollees – The Chronic Care Working Group is considering giving MA plans the flexibility to establish a benefit structure that varies based on the chronic conditions of individual enrollees. SCAN supports this policy option. Plans should be permitted to tailor benefits based on a beneficiary's specific needs and conditions. We also believe MA plans should be allowed to offer incentives to encourage engagement in wellness/care improvement activities focused on specific chronic conditions such as diabetes, heart disease and COPD.

We would note it is important to recognize that beneficiaries' needs vary not only based on chronic condition but also functional and socio-economic status. Flexibility, therefore, would be most beneficial if it addresses multiple factors and includes the ability to tailor to the unmet need of the individual.

[1] Additional information on IMPACT can be found at: http://impact-uw.org/

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill MA Enrollees – The working group is considering allowing MA plans to offer a wider array of supplemental benefits than they can today. SCAN supports this concept and recommends using a process similar to that used for Health Risk Assessments or state qualification for long term services and supports (LTSS). We also recommend developing a standard set of supplemental benefits, each with a standardized qualification process. Finally, we believe that capitation and requirements around the use of a plan's rebate dollars will collectively align incentives so that additional benefits are not misused or abused.

The aim of this provision is similar to the goal of the *Community Based Independence for Seniors Act (S. 704),* which unanimously passed the Finance Committee last June. SCAN suggests that the Committee would do well to include an updated version of S. 704 in any legislation reflecting the CCWG report. The House recently introduced a new version of the Community Based Independence for Seniors Act (H.R. 4212) which limits payment for the additional Home and Community Based Services covered in S. 704. This change was made in order to mitigate any CBO cost concerns, but also to ensure that health plans still have adequate resources to implement the demonstration.

Increasing Convenience for MA Enrollees through Telehealth – The Chronic Care Working Group is considering a policy option that would allow MA plans to include certain telehealth services in its annual bid amount. We believe that Medicare beneficiaries with chronic conditions would greatly benefit from an expansion of telehealth services available through the Medicare program. We strongly support a policy option that would give MA plans the ability to offer and be reimbursed for telehealth services as a part of the basic benefit package, without limiting payment for such services to the amount of supplemental benefit funds available. For an expansion of telehealth to be successful, we also believe it is imperative that the services be reimbursable for mental health treatment and in-home visits to assist frail individuals with mobility limitations.

Additionally, we believe that telehealth services should be expanded within urban areas where barriers to care still exist, though they may be different from those barriers faced by rural beneficiaries. Expanding access to telemedicine in a responsible manner makes sense because it improves access to care for beneficiaries, gives medical providers real-time data about their patients, and thus improves care itself.

Ensuring Accurate Payment for Chronically Ill Individuals – The working group is considering making changes to the Centers for Medicare & Medicaid Services (CMS) HCC Risk Adjustment Model to take into account additional health cost and socioeconomic factors associated with certain beneficiaries**.** We believe changes to the Risk Adjustment Model are justified given a recent study that concludes that CMS' current model under-predicts costs for individuals with multiple chronic conditions by $2.6 billion on an annual basis[2]. SCAN supports the working

[2] Analysis of the Accuracy of the CMS-Hierarchical Condition Category Model, Avalere Health, *January 2016*

group's proposed changes to the CMS-HCC Risk Adjustment Model and agrees they will result in more accurate payments for medically complex beneficiaries.

In addition, we support transitioning from a prospective model to a concurrent risk adjustment model for individuals with multiple chronic conditions. Concurrent risk adjustment uses conditions diagnosed in the prediction year to predict costs in the same year. We believe this approach will provide the most up-to-date and accurate data, particularly for a frail population, and will better reflect the true costs of providing high quality care to such beneficiaries.

Developing Quality Measures for Chronic Conditions – The Chronic Care Working Group is considering a policy option that would require CMS to include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease. SCAN is supportive of measures being more focused on health outcomes. Currently, a majority of the quality measures used in MA are process-focused measures. If we are able to, instead, look more closely at population-based measures, the resulting findings would allow plans to focus on primary outcomes, such as mortality and morbidity. This would be especially beneficial given that, when beneficiaries move from plan to plan frequently, it is difficult to maintain a cohort that is meaningful.

Study on Medication Synchronization – The Chronic Care Working Group is considering a study to promote medication adherence. That study would determine if 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, providing greater opportunity for the beneficiary to receive comprehensive counseling from a pharmacist. SCAN supports medication synchronization and recommends that any study be required to: (1) look at current barriers to coordination and how they could be overcome; (2) examine best practices used by commercial drug plans and retail pharmacies; and (3) include an assessment of the feasibility of such medication synchronization programs in Medicare. We also recommend that any such study include the insights of retail pharmacies, as they are an instrumental body to expand this practice.

Conclusion

While SCAN does not have specific comments on some of the additional policy options set forth, we generally support the following policies and appreciate the working group identifying them for further consideration: establishing a one-time visit code post-diagnosis for Alzheimer's/Dementia or other serious and life threatening illness to allow physicians additional time to fully explain the progression and treatment of the disease; expanding access to prediabetes education and digital coaching; and increasing transparency at the Center for Medicare & Medicaid Innovation.

We appreciate your consideration of the comments above and again thank the Chronic Care Working Group for its work to date. Your thoughtful approach to reforming health care coverage and delivery systems will ultimately better meet the needs of our frailest, most

elderly, and sickest populations. We look forward to our continued work with you on these issues.

Please do not hesitate to contact me at pbegans@scanhealthplan.com if there is anything more the team at SCAN can provide.

Sincerely,

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