Security Health Plan of Wisconsin would like to submit the following feedback as requested. We appreciate the opportunity and welcome further conversation.

1. **Improvements to Medicare Advantage for patients living with multiple chronic conditions.**
    a. We would recommend implementing alternatives to manage specific disease states or conditions outside of a MA-SNP plan design – such as a VBID for beneficiaries with specific chronic conditions. Under such a scheme, Medicare plans would be free to reduce cost sharing requirements for high value services (such as primary care services, chronic care services, and preventive services) while simultaneously increasing cost sharing requirement for services that are more volitional or shoppable.
    b. CMS will need to consider evaluating its stance on plan and benefit equality for each individual member. In order to adequately address chronic conditions, variations will need to occur at an individual level. Furthermore, it would be beneficial to incent behaviors specific to an individual's condition, rather than broad population-wide incentives
    c. For increased management of this population, we'd also propose the following: Allowing plans to cross-walk dual eligible members currently enrolled in MA-PD plans into MA-SNP plans; allow for mandatory care management for specific special needs; and greater flexibility to launch new above and beyond or care management programs mid-year (even though they may not be specifically listed within the plan bid).
2. **N/A**
3. **Reforms to Medicare's current fee-for-service program that incentive providers to coordinate care for patients living with chronic conditions**
    a. A move from a volume-based payment structure to a value-based payment structure that incentivizes efficient, high-quality care is necessary. The new payment structure should reward primary care providers for managing their patients' chronic conditions, as demonstrated through proven quality metrics. These pay-for-performance models should include incentives for quality, efficiency (total cost of care) and accurate risk coding. A portion of provider payments should be tied to these metrics, possibly in the form of payment bonuses or payment withholds.
4. **The effective use, coordination and cost of prescription drugs**
    a. A change in the Affordable Care Act to allow the Government to negotiate pricing with drug makers would have large-scale impact to the cost of prescription drugs, especially if those discounts could also be applied within the Medicare Advantage and PDP programs.
    b. From a coordination standpoint, we would recommend considering moving Part D covered immunizations to Part C for less confusing administration.
5. **Ideas to effectively use or improve the use of telehealth and remote monitoring technology**
    a. Remote access technologies present real opportunities for plans operating in rural areas with naturally limited provider networks and provider specialty availability. Some factors to consider specifically include: allowing these technologies to count towards certain network adequacy standards (e.g. dermatology, allergists, etc.); allowing remote access technology initiatives to begin mid-plan year as long as they are of benefit to the members; including these types of services within fee-for-service rather than requiring as supplementary benefits. Remote access technologies present an opportunity to provide services at a lower cost and equal quality. We strongly encourage these services to be considered for fee-for-service rather than supplemental to allow for minimal impact to member premium.
6. **Strategies to increase chronic care coordination in rural and frontier areas**
    a. See #4 above.
7. **Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers**

a. We would suggest requiring members with chronic conditions to enroll and participate in chronic condition care management programs. Currently care management programs are optional for all members which gives members the ability to opt out or refuse care coordination services. This is a significant barrier in the overall care of a patient. Furthermore, incorporating an Advanced Care Planning program within a chronic care management program would assist in educating members on the importance of quality vs quantity of life.

8. **Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions**
    a. The concept of population based payment is a worthwhile one; however, most primary care practices are poorly equipped to absorb risk for the management of their patient panel. A better approach might be to tie a moderate global payment rate to primary care practices with a gain share methodology for meeting certain quality and utilization metrics for the managed population on a risk-adjusted basis.
    b. As noted above, we suggest a move to a value-based payment structure for primary care providers that is focused on patient health outcomes. Payment structures must align with provider practices to focus on high-quality, lower cost care for patients that results in overall improvements to Medicare population health. This could be accomplished by creating a quality improvement pool coupled with a cost-reduction pool that could be distributed to primary care providers who meet pre-defined standards around chronic condition management.

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