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June 22, 2015

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: Chronic Care Reform

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

WellCare Health Plans (WellCare) thanks the Senate Finance Committee for forming a bipartisan chronic care working group and 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 May 22, 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 three 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.

Improvements to Medicare Advantage for patients living with multiple chronic conditions

<u>HCC Risk Adjustment</u>

In the 2016 Rate Notice, the Centers for Medicare & Medicaid Services (CMS) announced they were moving forward with implementing the clinically revised CMS-HCC risk adjustment model for 2016. The

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revised model reduces the value ascribed to each chronic condition in a beneficiary's overall risk score. The clinically revised risk adjustment model disproportionately impacts plans that serve higher proportions of dual-eligible members, as the dual-eligible members tend to have a greater number of chronic conditions as compared to non-dual eligible members. The reduction in payments through implementation of the clinically revised model will significantly inhibit a plan's ability to provide comprehensive and high quality care and disease management programs to benefit members with multiple chronic conditions. We recommend that Congress require CMS to further revise the risk adjustment model in a manner which supports the goals of early detection and intervention for Medicare beneficiaries with chronic conditions.

Low Socioeconomic Status / Dual Eligible Beneficiaries and the Medicare Star Ratings

There is a large body of third party and impartial research that supports the finding that individuals with low socioeconomic 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 complicating factors such as limited access to financial and community resources, lower levels of income and educational attainment, and worse health outcomes. This population also 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. For a high-SES beneficiary, adherence to multiple medications can present a challenge. For a beneficiary with low-SES and limited resources, this challenge can be compounded in many ways, including medication cost, low health literacy, and lack of access to transportation.

CMS uses a star ratings system 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 quality 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. A subset of these measures evaluates a beneficiary's ability to adhere to their 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

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

adherence.[2] In fact, a high proportion of low-SES enrollment is a strong predictor of low plan performance on quality measures overall.[3] 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. Given disparities between low-SES and higher-SES beneficiaries, and the correlation between low-SES, health disparities, and unhealthy behaviors, the star ratings methodology should account for the added challenges faced by health plans that serve individuals with substantial chronic care needs including individuals who are dually eligible for Medicare and Medicaid.

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.

The effective use, coordination, and cost of prescription drugs

Medication Therapy Management

As previously noted, Medicare beneficiaries with multiple chronic conditions frequently take numerous prescription drugs. Adherence to these medications is critical to maintaining their health and quality of life. Current regulations place limitations on a plan's flexibility to design and implement Medication Therapy Management (MTM) programs that effectively target beneficiaries most in need of the service, as the current qualification criteria includes a minimum annual spend of $3,183. Medicare plans should have the flexibility to customize their MTM programs for their individually enrolled populations, as there are many members who may need management but do not meet this dollar threshold. Individuals with an annual spend below the minimum could also benefit from MTM, but due to the current requirements, they are precluded from enrolling. Examples of customization include lowering the threshold for enrollment into an MTM program or allowing all beneficiaries taking any one of a set list of targeted drugs (insulin, warfarin, oral antiplatelets, or oral hypoglycemic) to enroll. By implementing such a change, plans serving chronic care patients would be able to improve quality of care, better manage pharmacy costs, and reduce the negative interactions between drugs for a greater proportion of their enrollees. We recommend CMS create an expanded MTM demonstration, in which Medicare plans are able to submit proposals to CMS for expanded flexibility and under which plans share the results of those pilots in order to identify best practices from Medicare plans around the country.

[2] Young GJ, Rickles NM, Chou CH, Raver E. Socioeconomic Characteristics of Enrollees Appear to Influence Performance Scores for Medicare Part D Contractors. Health affairs (Project Hope). 2014;33(1):140-146.
[3] Ibid.

Opioid Case Management

Medicare beneficiaries with complex chronic conditions frequently have comorbidities such as chronic pain, depression, or other behavioral health issues, requiring them to take opioids on a daily or near-daily basis. CMS requires Part D sponsors to establish reasonable and appropriate opioid case management programs that target utilization. However, there are currently no guidelines on management of these programs. Current guidance is vague, and there is uncertainly around which populations or patients are considered reasonable or appropriate for enrollment.

While many patients with chronic conditions benefit significantly from regular opioid use, there may be serious adverse side effects of daily or near-daily use, including slowed breathing, physical dependence, or sleepiness and sluggishness. For the patient's safety, basic guidelines of an opioid case management program should include history and physical exam, drug use screening, depression screening, and prescription monitoring. Additionally, to protect against "doctor shopping", it is advised that patients receive all opioid prescriptions from one physician and one pharmacy whenever possible. In order to provide the best case management for individuals taking opioids, we recommend that Congress require CMS to establish, with the benefit of stakeholder input, minimum program requirements, such as the examples above, for the opioid case management programs. CMS has the ability to help plans better develop and implement such programs by setting minimum standards upon which plans can build their programs. By creating minimum standards, plans will have needed guidance on the program expectations, but will still be afforded the flexibility to tailor their program and test program solutions.

Limitations on Usage of Literature in Safety Edits

Medicare plans face dispensing limitations based on medication package inserts as dictated by the Food and Drug Administration (FDA). Plans are unable to use the best and most recent evidence in prescribing practices unless they have been adopted and integrated into the package insert. For example, Cymbalta is a medication used for depression. The package insert lists the maximum dosage as 120mg, while more recent literature states that there is no additional effectiveness for any doses over 60mg/day. This creates waste in medication dispensing, as plans must rely on the information contained in the package insert. Additionally, recent literature may suggest that the package insert dosage is too high, though a safety edit is prohibited based on current standards. The limitation of the use of literature in prescribing practices prevents continuity of care and inhibits a plan's ability to effectively care for members. We recommend that Congress require CMS to provide plans the flexibility to consider the relevant medical literature in implementing prescribing protocols. For many medications, particularly medications which individuals with chronic conditions are currently prescribed, there is current literature supporting alternative prescribing practices. Allowing plans to put safety edits in place that are consistent with the most current and up to date literature as oppose to relying exclusively on package inserts, which are not updated as regularly, would be in the best interest of the beneficiary.

Ideas to effectively use or improve the use of tele-health and remote monitoring technology

Technologies that enable health care providers to furnish care to patients in locations remote from providers are increasingly used to complement and supplement face-to-face patient-provider encounters. The use of remote access technologies, such as telehealth, as a care delivery option for MA enrollees may improve the accessibility and timeliness of needed care, increase communication between providers and patients, and enhance care coordination. Telehealth also connects patients with services, including access to specialists, that may not be available locally and reduces the burdens associated with travel cost, time, and coordinating transportation, which can be a significant issue for low income and dually eligible beneficiaries.

We recommend a fully integrated approach to the delivery of health care via telehealth that utilizes health plans' integrated care platforms. Additionally, Medicare plans should have the flexibility to incorporate telehealth into their benefit offerings as a supplemental benefit. Providing coverage for this service 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.

A significant barrier that exists with regard to telehealth is licensure. 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.

Strategies to increase chronic care coordination in rural and frontier areas

There are unique challenges to delivering health care in rural and frontier areas, and they include provider shortages, isolation, long travel distances, scarcity of specialty care, under-resourced infrastructure, and a predominately older population with multiple chronic conditions. Care coordination is especially critical for rural communities. On average, rural communities report poorer health outcomes than their urban counterparts, with a higher prevalence of chronic disease, mental illness, and obesity.[4]

[4] *Mental Health and Rural America: 1994-2005.* Washington: U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 2005, *ftp://ftp.hrsa.gov/ruralhealth/RuralMentalHealth.pdf*

Rural communities generally have fewer physicians, nurses, specialists, and other health care workforce compared to non-rural areas. While there are incentives in place to encourage physicians to practice in rural areas, these incentives could be strengthened. The current National Health Service Corps (NHSC) policy for clinician loan repayment in underserved areas requires selected applicants to serve a minimum of two years in an NHSC qualified practice in an underserved community. To further address provider shortages in these areas, the minimum time commitment could be lowered to one year with the option to continue. Lowering the minimum number of commitment years may broaden the applicant pool and increase the number of clinicians interested in this program.

Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

A beneficiary's ability to manage his/her own health is a key component in maintenance of chronic conditions. It is not uncommon for socioeconomic factors, such as lack of transportation or instability of housing, to pose barriers for self-management and to prevent Medicare beneficiaries from receiving care. In 2012, CMS released a final rule that allowed certain Duals Special Needs Plans (D-SNPs) the ability to offer supplemental benefits beyond those permitted for MA plans, such as in-home food delivery, supports for caregivers, and home assessments/ modifications but the rule limited that flexibility to fully integrated and high performing plans. In the 2016 Call Letter, CMS expressed interest in increasing the number of D-SNP enrollees who benefit from this expanded flexibility. In order to more effectively meet the chronic care needs of this population, we recommend that Congress require that CMS allow all D-SNP plans the flexibility to deliver these quasi-social supplemental benefits. This expansion will offer plans the flexibility to provide their dual-eligible members with supplemental services specifically designed to enhance those members' ability to access services and self-manage their care.

Members often face complex medical, behavioral health and social needs. These issues can prevent individuals from accessing needed services in a timely way and can exacerbate their symptoms. These barriers make engaging and retaining individuals in their healthcare an even greater challenge. Many individuals have a limited understanding of the nature of their illness, including the symptoms, options for treatment and that recovery is possible.

Conclusion

WellCare appreciates the opportunity to provide comments on these important policy issues. Should you require further detail on any of our comments or recommendations, please feel free to contact me at (813) 206-5169. Thank you for your consideration.

Sincerely,

Elizabeth Cahn Goodman