January 26, 2016

Via: chronic_care@finance.senate.gov

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: Senate Finance Committee Chronic Care Working Group Policy Options Document

Dear Senators Isakson and Warner:

Thank you for the opportunity to comment on the policy options document of the Senate Finance Committee Chronic Care Working Group (Working Group). Centene Corporation (Centene) commends the Working Group’s effort to improve care for the millions of Americans managing chronic illness, and we appreciate the opportunity to participate in this bipartisan process.

Founded as a single health plan in 1984, Centene has established itself as a national leader in the healthcare services field. Today, Centene’s managed care organizations work with over 4.8 million members across 23 states. Centene provides health plans through Medicaid, Medicare and the Health Insurance Marketplace and other Health Solutions through our specialty services companies. We believe quality healthcare is best delivered locally. Our local approach enables us to provide accessible, high quality and culturally sensitive healthcare services to our members.

Centene also operates Dual Eligible Special Needs Plans (D-SNPs) in seven states and we participate in the Financial Alignment Demonstrations in five states. Centene has a history of serving low income and vulnerable populations. That is demonstrated by our commitment to the dual eligibles through our D-SNP products as well as our participation in the demonstrations.

Attached you will find a detailed list of comments and recommendations from Centene and our subsidiary, US Medical Management (USMM), a leading in-home health services company for high acuity populations. At the outset, Centene is pleased that the Working Group has recognized the success of the Independence at Home (IAH) Demonstration project. Making this into a permanent nationwide program would result in $50 billion in savings for CMS, according to University of Pennsylvania research.

Other comments we have provided are in regards to improving choice, access, benefits, payment and quality for the chronically ill in Medicare Advantage and Special Needs Plans. Regarding quality, we urge the Working Group to build on S. 2104 by Senators Portman and Casey and have included recommendations to address socioeconomic factors and social determinants of health in the MA Star ratings system. These factors are key to plans serving high proportions of duals and low-income members who are significantly more likely to suffer from multiple chronic illnesses. Finally, we have also included recommendations to improve care for the chronically ill in Accountable Care Organizations (ACOs).
Thank you again for the opportunity to comment and if you have any questions, please contact me at either 314.550.6739 or jdinesman@centene.com.

Sincerely

[Signature]

Jonathan Dinesman
Senior Vice President, Government Relations
Response to the Request for Comments:

United States Senate Committee on Finance
Bipartisan Chronic Care Working Group
Policy Options Document
ISSUED: December 2015

Respondents:
Centene Corporation and Health Plan Subsidiaries
U.S. Medical Management, a Centene Corporation Subsidiary
Expanding the IAH Demonstration into a Permanent Nationwide Program

USMM/VPA, a subsidiary of Centene Corporation, is the largest Demonstration participant in IAH, representing upwards of 35% - 40% of the entire Demonstration. Centene / USMM appreciate the Senate Finance Committee Chronic Care Working Group (CCWG) recognition of the thoughtful Congressional bipartisan design of the IAH program and the success the Demonstration is producing. Centene / USMM are pleased to respond to the CCWG request for feedback on questions related to IAH and to the CCWG policy options as outlined.

Centene / USMM is pleased with the efforts of the in addressing chronic care reform; further, the CCWG has generated an exemplary number of policy options leading with the expansion of the IAH Demonstration into a permanent nationwide program that will improve care for the chronically ill in this country and serve as a bridge to future population-level health initiatives.

We agree with the concept of improving care coordination for those living with a chronic condition. In particular, we support the policy goals of:

- increased care coordination among individual providers across care settings who are treating individuals living with chronic diseases;
- streamlining Medicare’s current payment systems to incentivize the appropriate level of care for beneficiaries living with chronic diseases; and
- facilitating the delivery of high quality care, improving care transitions, producing stronger patient outcomes, increasing program efficiency, and contributing to an overall effort that will reduce the growth in Medicare spending.

We also encourage the Committee to continue to find ways to increase coordination in the Medicare fee-for-service (FFS) environment where the payment incentives are particularly problematic for the chronically ill.

We are pleased that the first CCWG policy option discussed in the document is expanding IAH into a permanent nationwide program. The year one results of the Demonstration, as the CCWG well knows, were remarkably positive and we are optimistic that the year two and year three results will be even more positive than year one.

The CCWG requests feedback regarding program enhancements and changes to improve and expand the program.

We believe that Congress did an excellent job in the original design of the program. The targeting inherent in the initial design enabled the goals of the demonstration to be met in improving care, increasing beneficiary and caregiver satisfaction and reducing cost. This design, according to University of Pennsylvania research, will result in approximately 50 billion dollars in CMS savings over a decade of nationwide program implementation.

The design of IAH provides for the following:

- Enables IAH practices to have an immediate impact on the care and cost of services for the frailest and sickest of Medicare beneficiaries.
• Enables the Medicare program and the American taxpayer to appreciate the cost savings from this design.
• Produces savings that should be scoreable by the Congressional Budget Office (CBO) and thus assist the Senate Finance Committee in its next steps of having IAH become a nationwide program.

As evidence of the power of the IAH design in targeting the sickest and most expensive Medicare beneficiaries, the membership placed in the IAH demonstration represents:

• 6% of Medicare beneficiaries account for 30% of Medicare Parts A&B fee for service costs,
• 23% of all FFS deaths,
• 24% of all FFS hospitalizations,
• 45% of all FFS 30-day readmissions
• 39% of nursing facility (NF) long term institutionalization

These data support the idea that IAH and its expansion may be the single most powerful tool on a beneficiary by beneficiary basis to impact Medicare program cost and increase quality of care and beneficiary satisfaction.

We suggest that legislative language be included that specifies IAH as an Alternative Payment Model.

We believe that IAH may serve as a strong example of Part B practice transformation from "volume of services" to "value". IAH can also serve as a practice transformation catalyst within Accountable Care Organizations (ACOs), across Health Systems and in Health Plans. Along these lines we urge the CCWG to include legislative language that specifically identifies IAH as a permanent nationwide benefit and clarifies that IAH is considered an Alternative Payment Model as defined under the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA).

The CCWG also asks for recommendations regarding HCC scoring and alternative methods of identifying IAH beneficiaries. Our comments follow:

We recommend that the current effective beneficiary identification implicit in the IAH criteria be retained for the following reasons.

• IAH criteria require real time/prospective physician validation of beneficiary condition rather than retrospective HCC scoring. This provides for ongoing enrollment and the ability to timely intervene to improve care and reduce cost.
• HCC scoring used to identify the patient cohort of the IAH population is imprecise, flawed and lacks quality controls.
• HCC scoring will miss beneficiaries who would benefit from the IAH program given historic inaccuracies (undercoding) by Part B providers. As stated on p. 20 of the Senate Finance Committee CCWG’s report, “Research shows that the current HCC risk adjustment model under-predicts high cost, complex individuals.” To the degree that the current model performs poorly when predicting utilization and cost from beneficiaries with multiple chronic conditions, any classification using that model would likely result in under-predicting who will benefit, and should receive, important IAH services. Thus, we encourage completion of the proposed
evaluation and improvement of the risk adjustment model before utilization of HCC as a method of assigning services.

- Further, HCC scoring used to identify beneficiaries may increase volume, but would also dilute the care improvement and cost saving effectiveness of the IAH model as designed. This would undermine the shared savings incentives of the IAH program both for prospective IAH practices and also for the Medicare program.

The CCWG asks for other recommendations in light of a potential Program expansion. Centene / USMM recommendations include the following:

- Immediately remove the cap on the current number of beneficiaries who can receive IAH services by the existing Demonstration practices.
- Maintain current IAH practice requirements: The practice requirements as set forth currently are sound for initial participation for a practice to participate in IAH and to succeed. The requirement for yearly savings to be achieved serves as an effective means to eliminate practices that are not successful. Congress could have CMS review practice data in order to identify potential IAH practices, and determine, during application, which practices demonstrate an ability to manage an IAH like population.
- Maintain existing quality measures; The six quality measures currently tied to IAH shared savings successfully serve to orient the practices to the “proactive practice focused model” that Congress widely intended and that, as mentioned, is serving to transform practices and providers from volume to value.
- Improve data sharing: We recommend that the CCWG require improved data sharing between CMS and IAH practices similar to what CMS provides to participants in the ACO programs.
- Increased communication (data sharing) on a real time (monthly) basis is recommended to improve beneficiary management and tracking across settings. We are pleased that CMS / CMMI is currently taking steps to improve the quality and timing of data for the IAH Demonstration practices and we encourage Congress to assure that this is a feature of the nationwide IAH program.
- Consider evaluation of IAH for Medicaid program cost savings in terms of improved care and outcomes including cost savings on both a federal and state level.
- Improve the risk adjustment methodology that is currently in place for IAH. Centene / USMM provide specific recommendations below under the section on Risk Adjustment that includes a frailty factor in addition to other observations.
- Use the improved risk adjustment with frailty factor not only for IAH, but also have this risk adjustment appropriately attach and relate to an IAH beneficiary across all Medicare programs including MSSP, ACO, and duals programs where qualified beneficiaries could be enrolled.
- This IAH qualified beneficiary risk adjustment formula would also apply across measures and settings including current value based purchasing programs and would be applied under the Merit Based Incentive Payment System (MIPS) and to measures in the establishment of a payment model under the IMPACT Act. IAH risk adjustment benchmarking should be used for all chronically ill populations in all CMS payment models.

Requiring MA Plans to Offer Hospice Benefits

We are in favor of policies that lead to more integrated care especially if the integration is coupled with improved efficiency in administrative provisions. Carving out the hospice benefit is problematic both in
terms of integration of care for the member as well as confusion in terms of payment for services. We believe managed care entities can efficiently provide hospice benefits if they are adequately compensated in the capitation rate. In addition to changes in the FFS benchmarks used to establish MA rates and risk adjustment, including hospice benefits within Medicare Advantage could require modifications to the Star ratings program. Current Star ratings are largely based on measures addressing preventative healthcare and managing chronic conditions that are not applicable to the hospice population. For example, the current diabetes control measure is not suitable for someone who has a condition or is taking medications that would exacerbate higher HbA1c levels. CMS has already defined hospice measures (Hospice Item Set) which are more suitable to measure outcomes for this population. Thus, we recommend a distinct quality ratings system be developed based on the Hospice Item Set rather than including hospice in the current rating system. Should CMS decide to include these items in the Stars ratings system, we request clarification for the following issues:

- What would be the enrollment threshold for a contract to report on hospice measures?
- Would the hospice measures be a separate star rating from Part C and Part D?

We advocate for a collaborative measure development between measure stewards, hospice providers, Medicare Advantage plans, and other stakeholders, and look forward to a more substantive comment when measures are made available.

**Allowing End Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan**

Currently, no Star measures are explicitly applicable to ESRD beneficiaries. Quality measures regarding treatment of ESRD are more applicable to the hemodialysis treatment facility.

**Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations**

We strongly support the proposal to make SNP authorization permanent. SNPs have successfully served thousands of Medicare beneficiaries and are a proven delivery system for targeted populations. Permanent SNP authorization will reduce the uncertainty surrounding reauthorization and strengthen the business environment for these plans.

However, we would like to express concern about requiring availability of all Medicaid services in dual SNPs (DSNPs). This addition would enhance coordinated services to beneficiaries but will be very difficult to implement. Medicaid programs are owned and implemented by states, and there is currently no mechanism, or statutory authority, requiring states to enter into full dual eligible arrangements with Medicare Advantage managed care plans. Further, we have learned from the Financial Alignment Demonstrations that true integration goes beyond coordination of services. If integration is to succeed, we need the ability to integrate the administrative aspects of health care delivery. Due to the current statutory requirements surrounding Medicare and Medicaid, it is logistically very difficult and costly to try to adhere to two sets of statutory and regulatory requirements. Full integration needs the support of enabling legislation that will break down the silos between Medicare and Medicaid for the dual eligible population.
In order to offer a full range of Medicaid services in D-SNPs, states and DSNPs would need time to integrate those services between Medicaid and Medicare. Specifically, DSNPs would need to obtain all state-based historical claims data for beneficiaries. Finally, DSNPs would need ample time to ensure that provider networks are adequate and all materials and notices are approved by appropriate regulatory agencies prior to implementation.

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

We appreciate the effort to provide plans with the flexibility to tailor benefits to this specific population. However, we would like to point out that there are many logistical, service delivery, and performance measure issues that would require clarification. For example, Star performance measures are based on a set of quality measures that are consistent across states and plans. Introducing variation in benefits at the member level is likely to impact the ability of the Star measurement system to be a reliable source for plan comparison. We encourage the CCWG review early lessons learned from the MA VBID demonstration in devising approaches for addressing this issue.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

We request that CMS work with measure stewards for incorporation of telehealth as a data source for reporting on quality measures.

Ensuring Accurate Payment for Chronically Ill Individuals

We applaud the CCWG on its policy option to ensure accurate payment for chronically ill individuals. In particular, we agree that multiple chronic conditions for a member may not be recognized adequately in the risk adjustment process today. We also believe that comorbidity between behavioral health issues and chronic illness are not adequately addressed. Our experience with dual eligible and chronically ill individuals suggests that these very vulnerable populations utilize more extensive services, benefit from personalized attention, and often require help that is not traditionally recognized as a benefit under the current healthcare framework in order to maintain or improve health (i.e. transportation services, home modification). We fully support the proposed investigation of functional status as an addition to the risk adjustment model.

Our specific recommendations in support of this option are as follows:

Socioeconomic factors included in risk scoring

We encourage incorporating socioeconomic factors into risk adjustment. As the CCWG noted, these factors interact with health history information to predict 12% of variation in spending. Centene has experience in treating the most vulnerable Medicare beneficiaries and appreciates that these non-medical factors contribute to approximately half of the time that is spent with beneficiaries and caregivers to improve outcomes and avoid cost. We further encourage the Committee to study effects of comorbidity between socioeconomic factors and behavioral health and their applicability to risk adjustment, especially among dual eligible individuals. Note that the current poverty indicator in the HCC risk adjustment model relies on the presence or absence of at least one month of enrollment in
Medicaid. For DSNP populations this indicator may not fully represent the wide range of impacts of low socioeconomic status on the delivery and utilization of benefits.

IAH risk adjustment should “follow the beneficiary”

We recommend establishing a risk adjustment methodology specifically for IAH and IAH-equivalent beneficiaries. As the IAH beneficiary criteria reflect, this population has unique attributes that result in excellent beneficiary targeting. This targeting leads to the strong health outcomes and cost projection of the criteria as well as serves as the clinical and financial basis of the opportunities for providers to intervene to improve care and reduce cost.

Congress should study and require CMS to develop an IAH risk adjustment model for all Medicare beneficiaries who meet the criteria. The IAH risk formula as noted above should then attach and follow the beneficiary into Medicare programs through which their care is arranged. This would include ACOs, PACE, Medicare Advantage health plans and dual eligible managed care plans. The IAH formula would also attach to measures and payment models as the beneficiary receives care across settings.

The risk adjustment formula should include the following components that Centene and outside organizations, recognized by MedPAC and CMS, have analyzed:

A Frailty Factor should be included in IAH beneficiary risk adjustment

Analysis conducted by JEN Associates that has been shared with Congress and CMS reflects that the current risk adjustment for IAH-eligible beneficiaries is inadequate. An adjustment that reflects the additional beneficiary frailty with associated cost of IAH beneficiaries has been found to correct for much of this underestimate in cost projection.

The frailty factor tool could also be used by CMS and organizations treating Medicare beneficiaries as a means to identify potential IAH qualified beneficiaries.

Clinical instability event

The IAH formula should include an adjustment that reflects the clinical instability and associated cost around the time that an IAH beneficiary qualifies for IAH through inpatient admission. This qualifying event reflects instability and high cost. Accordingly, to assure accurate payment and encourage providers to treat IAH beneficiaries, an adjustment to payment should be incorporated that would be paid to the provider organization for a period of at least 4 months from the time that the beneficiary qualified for service as an IAH qualified beneficiary. Again, this adjustment would attach to the beneficiary and be paid regardless of whether services were provided under the auspices of an IAH practice, an ACO, health plan or other entity.

In summary, the addition of 3 elements below into the risk adjustment model will go far to ensure accurate payment for chronically ill beneficiaries.

- Socioeconomic factors
- Frailty factor
- Adjustment to reflect clinical instability and high cost at program entry for the IAH beneficiary
Establishing a High Severity Chronic Care Code

The establishment of a code or codes to reflect the additional non face-to-face time clinicians spend managing a complex patient’s care has been a longstanding topic of primary care service. We are pleased that CMS recognized the service and work of Part B providers in the establishment of the Chronic Care Management code (CPT 99490). However, as acknowledged by CMS, researchers, providers and the CCWG this code is insufficient to capture the time spent by clinicians in managing their complex patients.

Centene, with its experience of the IAH Program and other primary care practices who treat complex patients provides the following input:

- *Patient Criteria:* the patients who should be eligible for the high severity chronic care code, as suggested by the CCWG, include those with multiple chronic diseases or those with a dementia diagnosis or impaired functional status. The IAH qualifying criteria is instructive here and certainly the IAH criteria would identify patients who would benefit by an improved code.

This does not mean that beneficiaries would have to be home limited or part of an IAH practice. Our comment is offered to reflect that CMS has the ability to identify and confirm services to patients who would benefit from the high severity chronic care code.

There would also be a rising risk cohort of beneficiaries who would benefit from the service, that are complex and that are consuming significant amounts of practice clinician, social worker, nursing and care coordination staff time.

A corollary benefit of the above approach is the relationship to the risk adjustment recommendations previously noted. One can envision that as CMS identifies beneficiaries eligible for the high severity chronic care code that those identified as meeting the IAH criteria would have the IAH risk adjustment attached to their care and services across settings.

IAH formula would also attach to measures and payment models as the beneficiary receives care across settings.

- *Providers* who can render the high severity code would include practices organized around team based care such as found in the IAH legislation and CMS specifications. However, there should not at the onset be any additional accreditation or certification.

- *Methodologies for evaluation* to measure the impact, effectiveness, and compliance in relation to this new payment construct could include the limited and well-designed IAH quality measures that are outcomes oriented and tied to payment.

The high severity chronic care code will produce additional benefits for beneficiaries, the Medicare program and private health plans.
• The code will support the CCWG policy option for IAH to become a nationwide program.
• The high severity Chronic Care Code will provide a funding stream to practices that are preparing for IAH participation under expansion.
• More generally, the code will support practice transformation from the move from volume to value. This will help the country transition from a health care system based on volume to one based on value.

**Developing Quality Measures for Chronic Conditions**

Centene believes that most people want to have control over their health care. Encouraging patient and family engagement, shared decision making, etc., support that goal. We would like to caution the working group in efforts to use these measures as indicators of quality. Managed care plans are engaged in extensive, ongoing efforts to develop care plans and engage providers in care teams. However, coordinating time and resources between beneficiaries and providers is a significant barrier to fully implementing these efforts. Progress in these areas is slow, and these efforts are in their formative stages. We are concerned that adding another level of family engagement and/or shared decision making could overwhelm the capacity of today’s health care providers. We suggest that plans be given ample time to ensure the adequacy of provider networks prior to any implementation of new quality measures.

Centene agrees with many of the metrics under consideration for this population; however, we are concerned that several of the current quality metrics that may apply to a broader Medicare population may not apply to a chronic illness population. Much like the consideration given to the duals population on HCC scoring, we believe there are metrics that should be dropped for the chronically ill but also suggest new quality measures be developed for this space. In this regard, we consider some of the community-level measures to be difficult to control for the chronically ill, such as obesity. The combination of chronic illness and environment limitations that limit quality benchmark achievement should be further investigated by CMS.

**Encouraging Beneficiary Use of Chronic Care Management Services**

Centene provides its strong support for the waiving of beneficiary copayment for the Chronic Care Management (CCM) service CPT 99490, and recommends this exact option in the 2016 Physician Fee Schedule proposed rule comments. Beneficiaries, as the CCWG has heard, have objected to paying for service that is not face-to-face and in addition often do not want to add to the copay cost of receiving medical care.

As a result, beneficiaries particularly those who would most benefit from the CCM services are electing to not receive service. This includes beneficiaries who for financial reasons do not have supplemental policies in effect. Eliminating this obstacle to CCM service is expected to improve care and reduce cost for the beneficiaries who receive care after Congress waives the copayment.

Similarly, Centene fully supports the CCWG recommendation to waive the copayment for the proposed high severity chronic care code described above.

The waiver of copayment for these services should address the goals of 1) incentivizing beneficiaries to receive these services and 2) address the concern of beneficiaries who would question CCM services
that appear on summary of benefit notices because they do not involve a face-to-face encounter and confuse the beneficiary.

**Providing ACO’s the Ability to Expand Use of Telehealth**

Providing ACOs the ability to expand use of telehealth should be accepted only when the service creates clinical or social advantages that lead to better clinical outcomes. Centene recommends using the technology to extend care longitudinally for the chronically ill. Where specialties and other clinical services are limited in their ability to reach the chronically ill with functional impairment, this technology can supplement primary care. We also recommend that telehealth be controlled through a partnership between case management and primary care to coordinate delivery and appropriate use of service. The home should be allowed as an originating site of service.

Centene fully supports adding the home as an originating site that is supplemented with primary care. Ideally, care coordination through telehealth for the chronically ill home bound would be collaborative, with contributions from case management, the patient, and the primary care provider in consultation within the home. This could be a very unique and effective use of the technology. Centene requests that the CCWG specify the appropriate data source and measure stewards for telehealth utilization/member experience data for any future quality reporting metrics. We agree with CMS that the use of a primary care provider and the use of primary care telehealth could be duplicative if not conducted by the same primary care office in a coordinated fashion.

**Maintaining ACO Flexibility to Provide Supplemental Services**

Centene fully supports giving ACOs the flexibility to provide social service and transportation for the chronically ill. We view this as a key determinant in mitigating current conditions and would be coordinated through high-severity chronic care management. The presence of mental impairment only heightens the need for these services.

**Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization**

Centene agrees that beneficiaries that volunteer to be in an ACO should be allowed to receive services from providers that are not in the ACO. However, should an ACO meet network criteria of CMS (such as the network criteria for MA plans), only then should guidelines be developed for the beneficiary to stay in the ACO. In such a case a different class of ACO should be developed (such as a network ACO) in which care would be coordinated within to increase value and effectiveness.

We agree that prospective assignment and voluntary enrollment should come with upfront collective payment. The current payment that lags care delivery, care management expense, technology use, etc. places capital stress on primary care practices that operate at small margins or lack size to scale efficient use of capital.

**Developing Quality Measures for Chronic Conditions**
Centene agrees with many of the metrics under consideration for this population; however, we are concerned that several of the current quality metrics that may apply to a broader Medicare population may not apply to a chronic illness population. Much like the consideration given to the duals population on HCC scoring, we believe there are metrics that should be dropped for the chronically ill but also suggest new quality measures be developed for this space. In this regard, we consider some of the community-level measures to be difficult to control for the chronically ill, such as obesity. The combination of chronic illness and environment limitations that limit quality benchmark achievement should be further investigated by CMS.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

Centene believes ACOs should have the flexibility to waive all copays and deductibles for primary care and common use lab, radiology, and diagnostic services necessary to manage this population. Considering many in this population have cognitive impairment eliminates in many cases the utilization reduction intended with these mechanisms. Additionally, the CCWG should consider the application of coinsurance and ACO flexibility to modify coinsurance requirements.