

David Schwartz
Head of Global Policy
Cigna Federal Affairs



June 22, 2015

VIA ELECTRONIC SUBMISSION TO http://www.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

Dear Senators Isakson and Warner:

Cigna welcomes the opportunity to offer ideas and insights in response to the Senate Finance Committee's request for stakeholder input on improving care for chronically ill beneficiaries throughout the Medicare program. 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 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.

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna"), is a global health services organization dedicated to helping people improve their health, well-being and sense of security. Our subsidiaries are major providers of medical, dental, disability, life and accident insurance and related products and services. Worldwide, we offer peace of mind and a sense of security to our customers seeking protection for themselves and their families at critical points in their lives.

We serve over two million Medicare and Medicaid beneficiaries through our MA, Part D, Medicare Supplemental, and Medicaid offerings. Our focus on this market has allowed us to develop a unique approach to healthcare coverage for beneficiaries, many of whom live with chronic conditions. We have a deep understanding of the needs and challenges facing both patients and physicians, and thus have developed a collaborative model that provides more access to high quality care for our customers while supplying physicians what they need to deliver that care.

"Cigna" is a registered service mark, and, "the Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc

David Schwartz
June 22, 2015
Page 2

Our suggestions for improving care for Medicare patients with chronic conditions in the Medicare Advantage and FFS programs are outlined below. We would be happy to provide any additional information or perspectives that would be helpful to you. Please let me know how Cigna can assist you in this important work.

Thank you for your consideration of these comments.

Respectfully,

David Schwartz

cc: Senator Orrin Hatch
Senator Ron Wyden

Chronic Care in Medicare Advantage

While we believe that there are opportunities to bring greater care management for chronically ill beneficiaries to the FFS Medicare program, we know the opportunity for high quality chronic care and the promise of better health outcomes for patients with chronic illness exists in the Medicare Advantage (MA) program today. Medicare Advantage plans offer benefits and services that are designed specifically for those with chronic illness, including:

- Case management services
- Disease management programs
- Coordinated care programs
- Prescription drug managements tooled integrated with medical benefits
- Nurse help hotlines
- Enhanced coverage of home infusion, personal care, and durable medical equipment.

Given the proven effectiveness of MA in delivering better care and outcomes for chronically ill members, the challenge becomes how to create the right incentives for beneficiaries who have chronic illnesses to enroll in MA, and how to ensure that MA plans have the right incentives to serve these beneficiaries.

Bringing Chronic Care to Dual-Eligible and Low-Income Chronically Ill Members:

The second challenge, of ensuring that MA plans are able to serve the chronically ill, requires recognizing the unique barriers that plans face when they serve these members, and adjusting the existing payment and quality rating systems to recognize 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 benefits. 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. Over 30 percent of Cigna-HealthSpring’s MA members currently are dually eligible for both Medicare and Medicaid benefits and services, compared with about 18 percent of the MA population overall. While the majority of our dual members (66 percent) are enrolled in special needs plans (SNPs) specifically designed to address their needs and that assist members with accessing and coordinating benefits across programs, a significant number of dual-eligible members choose to enroll in our regular MA offerings.

Dual-eligible beneficiaries, out of all our beneficiaries, derive the greatest benefit in terms of quality health outcomes – and improved quality of life – from the coordinated care that our MA plans provide. Research consistently shows that patients with chronic illness who are enrolled in MA receive more effective and appropriate care, have fewer hospitalizations and hospital days, and have a lower rate of complications than similar patients in the FFS program.^{1, 2, 3, 4}

¹Cohen, R, et. al., “Medicare Advantage Chronic Special Needs Plan Boosted Primary care, Reduced Hospital Use Among Diabetes Patients” *Health Affairs*, 31, no.1 (2012):110-119.

Our decades of work on behalf of Medicare beneficiaries show that achieving high-quality health care and better outcomes for members with chronic illness is a team effort involving the health plan, providers, and patients. Our experience at Cigna-HealthSpring clearly demonstrates that dual-eligible beneficiaries have a more difficult time achieving desired quality health outcomes, such as screenings and preventive services, adhering to prescribed medication regimens, or following through with basic treatment recommendations. Socio-demographic factors, such as language barriers, nutrition, and housing, play a key role in keeping some members from achieving better outcomes, despite having access to the same providers, services, and benefits as all members. For example, low-income members may not follow through on recommended screenings or preventive care, or may have difficulty with medication adherence, because they lack access to transportation. Our dual-eligible population requires tremendous investment in resources such as social workers, behavioral health specialists, nurse practitioners, in-clinic pharmacists, and other physician extenders to address the medical and social issues that often keep dual members from achieving the same health care goals and outcomes as other members. Ensuring that prescriptions are filled, medications are taken as prescribed, screening appointments are kept, and diagnostic tests are performed often means adding additional benefits such as transportation services, social workers, pharmacists, or advanced care nurses to supplement the traditional care teams that typically meet the needs of non-dual patients.

Unfortunately it is becoming more difficult to continue bringing the benefits of greater chronic care and intensive services to the dual-eligible population. Because the Stars Quality Rating System for MA plans fails to recognize differences in the population that plans serve, it results in biased ratings that in turn reduce payments (higher benchmarks and rebates that accompany higher Star ratings) to plans that serve a larger share of dual-eligible and low income members. These reduced payments lead to reduced benefits and services in plans serving such members, and threatens access for these populations.

CMS, along with other key groups such as the National Quality Forum and MedPAC acknowledge the disparity in Star ratings and are studying potential ways to address the problem. In the interim, a coalition of MA plans that serve a disproportionate share of dual-eligible and low-income members has developed a short-term proposal to correct the disparity using information about a plan's share of dual-eligible and low-income members and its demonstrated efforts to improve chronic and preventive care for its members.

We believe that an immediate, short-term solution is required to protect access to plans that serve a large share of dual-eligible and low-income chronically ill members. Until a long-term structural solution is developed, this short-term approach must hold plans accountable for providing high quality coverage, while recognizing the outsized challenges that increase as a plan's share of low-income membership increases up the continuum. Under our suggested proposal, plans would be eligible to earn an adjustment to compensate for the structural bias in the Star Ratings against plans serving low income members. The eligibility for and amount of the adjustment would be based on a contract's statistically significant improvement on the subset of measures and the contract's share of low-SES membership. The adjustment would apply to a plans' Overall Star Rating as well

² Landon, BE, et. al., "Analysis Of Medicare Advantage HMOs Compared With Traditional Medicare Shows Lower Use Of Many Services During 2003 -09." *Health Affairs*, 31, no.12 (2012):2609-2617.

³ Kaplan, J, et. al. "Alternative Payer Models Show Improved Health Care Value." May 2013, Boston Consulting Group.

⁴ Lemieux, J, et. al. "Hospital Readmission Rates in Medicare Advantage Plans." *Am J Manag Care*. 2012;18(2):96-104

as its Part C and D Summary scores, as shown in Table 5. We would be happy to provide additional information about the proposal to the Committee.

Table 5. Proposed Short-Term Adjustment to Stars Rating System

| | Statistically significant improvement on at least 25% but less than 30% of the measures within Part C Domains 1&2 and Part D Domain 4 | Statistically significant improvement on at least 30% but less than 35% of the measures within Part C Domains 1&2 and Part D Domain 4 | Statistically significant improvement on at least 35% but less than 40% of the measures within Part C Domains 1&2 and Part D Domain 4 | Statistically significant improvement on 40% or more of the measures within Part C Domains 1&2 and Part D Domain 4 |
|------------------------|---|---|---|--|
| 20-34% of LIS Cohort | 0.1 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.2 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.3 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score |
| 35-49% of LIS Cohort | 0.2 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.3 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score |
| 50-74% of LIS Cohort | 0.3 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score |
| 75%-100% of LIS Cohort | 0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score | 0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score |

Value-Based Insurance Design:

Value Based Insurance Design (VBID) that incentivizes beneficiaries through cost-sharing and benefit design to use high-quality/lower cost providers and allows incentives for participation in healthy activities would reduce costs and increase quality. Allowing 'non-Medicare' benefits to be offered as part of a coordinated care plan would improve overall care and outcomes.

An example of a cost-sharing benefit design that could be considered includes the ability to waive or reduce cost-sharing requirements when a beneficiary is participating in an intense care plan that involves frequent physician interventions. Intensive chronic management care plans may entail daily or weekly provider visits for a period of time. Requiring that the beneficiary be responsible for the applicable PCP or office visit coinsurance is a financial deterrent to following the care plan. Having the ability to selectively waive coinsurance requirements for beneficiaries participating in such coordinated care programs will increase compliance. In order to ensure adequate beneficiary protection, MA-PD plans should submit their decision-making process and criteria for CMS review and be prepared for CMS audit of activities.

Another example would be a cost-share differential if the beneficiary will agree to use providers that have proven high-value outcomes in treating chronic conditions. Ensuring beneficiary access to care with a reasonable number of options and within reasonable traveling distance is imperative, but the ability to have a tiered network design that offered greater benefits and incentives for beneficiaries to use high-value providers would result in better care delivery and quality outcomes. MA-PD plans should be allowed to tier their network within a PBP, but the criteria for provider inclusion in each network tier should be open to CMS review and made transparent to beneficiaries. This could be accomplished through designation of high-value providers in directories, educational materials explaining why a provider is designated high-value, and transparency around quality outcomes.

Examples of incentives for participation in healthy activities include monetary rewards or other items of value for closing gaps in care, participating in wellness services or completing some physical activity goals. The current limit of \$15 per member per year value for any incentives is not sufficient to impact beneficiary behavior. Incentives need not be exclusively cash rewards, but may include reduced coinsurance requirements, food coupons, or reward items generally considered of interest to the beneficiary population such as canes, home assistance items, and alert devices. A rewards program could be implemented and administered by a third party, with eligibility for the reward provided by the MA-PD plan as encounter data documenting participation in the desired activity is recorded. Identified activities and corresponding rewards should be open to CMS review. Transportation for non-emergent services PCP visits, lab draws, specialist visits, gaps in care closure, and dialysis are examples of a “non-Medicare” benefit that should be offered to chronically ill beneficiaries to improve overall care. Care plans often involve frequent provider visits and the lack of transportation is a deterrent to compliance. MA-PD plans are not currently allowed to offer transportation other than through a supplemental benefit offering, which is not feasible for all PBPs and is generally limited in the number of trips available. MA-PD plans should have discretion to provide transportation to a beneficiary, generally through a third party vendor, when the lack of transportation is a barrier to compliance with a care plan. MA-PD plans should have clear guidelines and criteria for when transportation benefits, other than supplemental benefits, will be provided and such guidelines and criteria should be open to CMS review.

There are other services that are not traditional Medicare services but that are crucial to ensuring a beneficiary may remain in the community versus the alternative of becoming institutionalized. These services include the installation of wheelchair ramps, bathroom safety devices, and climate control. Many MA-PD plans have experience in providing these services to Medicaid beneficiaries and a similar network for long-term care providers could be leveraged for Medicare beneficiaries. Again, MA-PD plans should have clear guidelines and criteria for when the “non-Medicare” services will be provided and such guidelines and criteria should be open to CMS review.

CMS should consider chronic conditions such as Congestive Heart Failure, chronic kidney disease, end stage renal disease, Chronic Obstructive Pulmonary Disease and certain behavioral health diagnoses such as major depression; due to the high prevalence and impact on the member functioning and maintenance within the community. This population has multiple needs, many of which are not being met to allow them to function as independently as possible. Several of these needs are medical such as medications and adherence, and compliance with treatment recommendations. Others include needs that require non-traditional assistance such as transportation assistance for both medical and non-medical needs, shopping assistance, finances, etc. Quality measures to be tracked during a model test should include acute care admissions, emergency room admissions, of gaps in care, medication adherence, and Health Outcome Survey results. Beneficiary protections should include all current protections with allowances for the use of “non-Medicare” providers and clinical/social need-based benefit application to provide extra benefits to those who could really benefit from them.

MA-PD plans do not currently have discretion to reduce the cost-sharing element, even when cost share is a barrier to compliance with a care plan. Cost-sharing should be eligible to be waived or reduced when a beneficiary is participating in an intense care plan that involves frequent physician interventions. Additionally, a cost-share differential should be permissible if the beneficiary will agree to use providers that have proven high-value outcomes in treating chronic conditions. MA-PD plans should have clear guidelines and criteria for when the cost sharing may be waived or reduced and such guidelines and criteria should be open to CMS review. One important consideration would be that the model allow for current non-covered services such as providing home access, non-clinical patient navigator aides, and other services designed to provide support in order to maintain the member safely within the community. This would create savings through reductions in acute-care services such as emergency room and hospitalizations without a negative impact to the beneficiary. Additionally, the model should be designed to provide support for the beneficiary such as reduction of key co-pays for select preventive and acute management services of key chronic conditions. This would benefit CMS by enabling greater access and coordination of services for the beneficiary by reducing their reliance on facility based services to resolve their concerns. By providing these types of services while reducing costs of select services ‘outside the standard regulations’ allows the patient to maintain and/or increase activity within the community in order to be more adherent to treatment programs and processes.

Tiered network design with coinsurance differentials, paired with beneficiary incentives for healthy initiatives, and closure of gaps in care are necessary to achieve a benefit design tailored to chronically ill beneficiaries. Intensive outpatient services in behavioral health and substance abuse settings are not currently covered by Medicare, but should be considered as part of a VBID.

The ability to offer non-clinical services as needed to improve clinical outcomes is crucial to potential success. Home assistance, wheelchair ramps, ensuring beneficiaries have transportation to their health care providers, adequate climate control in the home and nutritious meals all contribute to the ability of a beneficiary to remain in the community.

Telehealth:

Cigna believes that telehealth can play an important role in providing access and preventing chronically ill patients from experiencing acute events that too often result from poor care coordination in MA and FFS

Medicare. Our recommendations regarding telehealth revolve around two areas of emphasis: telemonitoring and virtual telemedicine visits.

Telemonitoring has demonstrated value with regards to decreasing utilization both in the medical literature and in our experience at Cigna-HealthSpring. Bluetooth enabled scales and blood pressure cuffs allow a case manager to monitor a patient's weight from home and intervene when their weight is beginning to fluctuate before they begin to have clinical symptoms. Telemonitoring also allows the case manager to call the patient when they stop weighing or checking their blood pressure regularly. Therefore, whether it is a patient with congestive heart failure (CHF), chronic obstructive pulmonary disease or diabetes, it creates accountability and ultimately a behavioral change for the patient that results in self-management of their disease. For example:

- In the medical literature, telemonitoring for CHF has demonstrated anywhere from a 44-56 percent reduction in all-cause admissions. In our own experience with telemonitoring for CHF, we have seen 50-52 percent reductions in all-cause admissions. At a minimum, telemonitoring for the first 30 days after a hospital discharge can reduce readmissions, but the real value is in using telemonitoring for those with CHF, diabetes or COPD *before* they are admitted to the hospital or utilize the emergency room.
- An ongoing study being conducted with an institutional partner is testing using telemedicine to improve care for diabetic patients in an underserved rural area. This institution, (which for confidentiality purposes, shall remain unnamed), has enrolled over 100 diabetic patients who had admissions in the past year. After 9 months, not a single patient has been admitted to a hospital or been to the emergency room. At the same time, medication adherence has increased to 96 percent.

The other area of telehealth that may be an area of focus is that of virtual telemedicine visits – virtual visits between a health care provider and a patient that occur remotely. Currently, CMS does allow for these types of visits to occur; however, the visits are restricted to certain medical facilities. Cigna recommends expanding the allowed telehealth locations to include the patient's home. There are many patients that cannot get to a provider's office for a variety of reasons that were outlined earlier in this document (travel limitations, financial limitations, etc.). In addition, there are many patients that live in rural areas and are 50 or more miles away from the nearest specialist. Allowing patients to have access to health care providers from their homes would enhance the delivery of care to chronically ill patients who require more frequent interactions with their providers.

Rural considerations:

We believe that the rural population has some challenges from a management perspective that should be addressed through both some changes in current structure and some innovative processes that will allow for greater care and quality.

One consideration would be addressing the issue of access to care. Currently, it is often a struggle to have MA plans and even Medicare FFS providers form an adequate network in many rural areas. Therefore access to both preventative and well as acute care can be a struggle of beneficiaries. One solution would be related to increasing coverage and standardizing pricing coverage for telemedicine. Currently, coverage is limited and does not allow for the appropriate use of this modality for provision of services that could encompass both preventative services and acute services. It would also be very beneficial to have standards around the pricing for expanded services for consultations and evaluation and management codes that could be provided through a telemedicine services.

Another consideration would be a price differential for a rural area for specialist services. While area designated as a Health Professional Shortage Area (HPSA) do allow for this, many rural areas do not qualify and as a result, tend to be underserved by specialists whose care is often essential to the continued wellbeing of the beneficiaries. We recommend that the Committee consider allowing a sliding payment scale for more critical specialties such as psychiatry and endocrinology in these underserved areas. Often beneficiaries cannot access the specialized care that these providers provide that enhances the overall care of the individual beneficiary. Another approach would be to pay a consultation fee to consulting specialists when they provide a telephone consultation to the primary care provider. This would allow for greater access to specialist services, contain the service within the primary care practice, and encourage greater coordination of care and planning for the beneficiary.

A third consideration would be related to allowing for in home services such as emergency monitoring devices, meals on wheels for short term post hospitalization for stabilization due to impairment from the hospitalization, similar to Medicaid for these beneficiaries. There is good evidence that basic needs such as nutrition post hospitalization can enhance and stabilize the return back of the beneficiary to the community. Often they're struggling to be maintained within the home setting due to poor access to care and ability to self-manage becomes problematic. By providing such services as part of a coordinated plan of care with their Primary care provider, this would enhance the development of self-care management, and maintained within a home setting for a longer period of time safely.

Pharmacy:

Often local pharmacies deliver prescriptions to Medicaid members to support compliance and medication adherence. A consideration for the Committee would be to allow a set fee for this type of service to further enhance compliance and adherence for primary and secondary prevention of medical conditions in Medicare.

Another consideration would be to create a quality incentive program for pharmacies to participate that would help beneficiaries with medication adherence and compliance along with avoidance of use of high risk medications. The local pharmacy can be a vehicle for patient education, coordination of management around select medications and enhanced monitoring for adherence to medications – which are all issues that members have in dealing with their often complex medication regime. Such a program would provide tiered incentives to the pharmacy for rates of compliance to medications and avoidance of high risk medications based on volumes of patients hitting certain metrics.

Bringing Chronic Care to the Medicare Fee-for-Service (FFS) Population

As the letter to stakeholders states, the FFS Medicare program struggles to create the right incentives for providers to engage in time-intensive patient care coordination and intervention. Another key challenge for improving care coordination in the Medicare FFS program is finding a central point of connection from which to educate and engage the beneficiary on the value of chronic care management.

One potential connection point for the substantial portion of FFS beneficiaries who have a supplemental Medicare plan (“Medigap” plan) is the Medigap payer. Medigap products are designed primarily to protect Medicare beneficiaries from high or unexpected out-of-pocket medical costs, which is critically important since

Medigap enrollees are shown to be at low income levels (94 percent of rural Medigap policyholders and 90 percent of all Medigap policyholders have incomes of \$50,000 or less). According to research published in *Health Affairs*, Medigap beneficiaries are, on average, more likely to have multiple chronic conditions that are complex and expensive to manage compared to Medicare beneficiaries as a whole.⁵ The prevalence of chronic illness in this population presents unique opportunities to interact with these Medicare enrollees in new ways to help them improve their own health status. Medigap payers could leverage both their existing relationships with FFS beneficiaries and the comprehensive claims information they gather as part of processing payments to identify beneficiaries in need of chronic care services and engage these beneficiaries in care management programs.

Medigap insurance must, by law, cover the cost-sharing amounts as specified by each plan's minimum standards for each claim that is crossed over to them from the fee-for-service claims administrators known as Medicare Administrative Contractors (MACs). As such, decisions about what is and is not medically appropriate for each patient are made by the physicians treating them and the MACs adjudicating the claims. Only after a determination of appropriateness has been made are the claims sent to the Medigap carrier for payment of the supplemental benefit, and the Medigap carrier must pay those claims based upon the type of Medigap product chosen by that enrollee. In other words, the Medigap carrier does not control what services are or are not paid for. This distinction is important because it explains why Medigap carriers cannot directly manage or coordinate care as they have no direct control over what services are delivered to the beneficiary. However, Congress can support those Medigap carriers that are exploring other ways they can interact with their members to assist them in interfacing more efficiently with the Medicare system.

Cigna serves as a Medigap provider to almost a quarter million FFS Medicare beneficiaries today. In addition, we serve more than 15 million customers through our commercial and Medicare Advantage businesses, and have a wealth of experience in designing and delivering chronic care management programs to patients that deliver proven results in improving health and lowering costs. Based on this experience, we offer a vision for bringing the programs to the FFS Medicare program

Cigna recommends that Congress support the current efforts of some Medigap insurers, and the Center for Medicare and Medicaid Innovation (CMMI) to develop voluntary model demonstrations that show how FFS Medicare and private Medigap insurers can work together. One such example is a "beneficiary health support" pilot currently under development that has the potential to improve enrollee health and efficient interaction with the Medicare system, thus generating savings for the Medicare program and for Medigap products. If appropriately structured and funded, we believe that more Medigap carriers will be interested in participating in such a voluntary enrollee health support pilot to help their members suffering from chronic conditions. We believe managing chronic illness is a total population health management solution, because the medical needs of beneficiaries will vary over their lifetimes. We recommend focusing on how beneficiaries will move along a spectrum of health, thereby lowering cost and improving quality earlier versus waiting until their conditions have become high-cost and medically-complex. The recommendations below depend heavily on implementation of information flows and timely exchange of information to facilitate the proper level of identification and management. Certain types of data and information that would assist in ongoing beneficiary support are

⁵ Lemieux, Jeff, et. al., "Medigap Coverage And Medicare Spending: A Second Look." *Health Affairs* March 2008 vol. 27 no. 2 469-477.

currently not available to Medigap, or Medicare Advantage carriers. We recommend that Congress convey to CMS that they should make such data available to participating Medigap carriers. For example:

- Data on prescriptions and drug claims are currently not shared with carriers. Making such data available to carriers could significantly increase the effectiveness of a pilot program for beneficiary health support services, by giving them key information about their health status and that can be gleaned from prescription information.
- Data on claims for which there is no Medigap responsibility (e.g., claims that are 100 percent paid by Medicare FFS) also should be made available at no additional cost to carriers. Such claims data can assist pilot carriers in understanding totality of the needs of each enrollee.

In addition, we recommend that Congress ask the National Association of Insurance Commissioners (NAIC), as the primary regulators of Medigap insurance, to assess current Medigap products to report on whether state regulators should be given flexibility to allow for new cost-sharing options to encourage collaboration between Medigap carriers and fee-for-service providers that are developing innovative care management models. This Congressional request to the NAIC could include an assessment of the Medicare Select program to see if modifications in that program might enhance collaboration between Medigap insurers and providers (hospitals and physicians) that are using cost-sharing in their care management structures, and a call for other plan innovations that would enhance the value of Medigap while also encouraging collaboration between Medigap carriers and fee-for-service providers. These models could include value based insurance designs or accountable care organization (ACO) arrangements that apply to both Part A and Part B services.

The recommendations also require proactive and ongoing communication with beneficiaries about what services are available to them as well as the ability to interact with providers.

Because state regulation of standardized Medigap plans is an important component of consumer protection, it would be important to structure the services envisioned in this pilot as separate and apart from the standardized benefit structure of Medigap plans offered to seniors. We recommend that Congress clearly state that pilot programs involving Medigap are constructed so that additional services offered through the pilot are not intended to change the currently standardized Medigap benefits, but rather are delivered as a service to Medigap beneficiaries in addition to the supplemental benefits offered through their Medigap coverage.

One key to a successful pilot would be for Congress to require that CMS create a financing structure that allows carriers of various sizes and structures to participate. Building the suggested beneficiary support services would require the expenditure of resources by carriers, particularly in the case where a carrier may need to look to third parties for such services, resulting in the need to build an internal infrastructure that allows them to track, measure and report on the program operations. One potential avenue to explore is sharing savings with Medigap carriers, as has been done in past demonstrations, and funding of up-front costs, with the potential for recoupment as savings are realized. Another suggestion would be for Congress to direct CMMI to release a grant funding opportunity from existing CMMI funds that would be earmarked for insurers and other stakeholders to work together to innovate around enrollees that are on Medigap. Both of these funding ideas could encourage broader adoption of the potential successful processes and techniques demonstrated under the pilot program.

These programs could be used at the carrier level (Cigna only) or Cigna could provide them for the total Medigap population. Creating and implementing the programs discussed above should not require intervention from state regulators unless:

- Programs are deemed to be a change in benefit structure that would result in the Medigap benefits not being standardized
- A strict interpretation of the regulations indicated a prohibition on Medigap carriers collaborating with providers in a non-network construct
- Programs are deemed a requirement for members

Below, are beneficiary tools and services we utilize in our MA and SNP plans and suggest the Medigap program have the ability to utilize them to properly identify and stratify beneficiaries.

Health Risk Assessment (HRA):

- The tool is intended to identify the care needs of the beneficiary upon enrollment and on an annual basis
- Assessment of medical, psychosocial, cognitive, and functional needs of the beneficiary and includes medical and behavioral health history
- Beneficiaries who are stratified as higher acute or chronic risk would receive a further assessment called the Risk Triggered Clinical Assessment (RTCA), and, if needed, a Behavioral Health Care Coordination Assessment (BHCCA)

Case Management: Should a referral to case management be triggered by an HRA, acute admission, or other change in condition, a case manager conducts a comprehensive assessment of the medical, psychosocial, cognitive, and functional needs of the member and includes medical history as well as environmental influences

Health Risk Management Program:

- Sub-stratify populations within the Health Risk Management Program based upon identified risk, lifestyle choices (tobacco or substance use), referrals, and identified needs
- Interventions available to members (varies based on sub-stratified population) include:
 - Self-management educational communication
 - Offering of individual support for self-management if beneficiary desires to become engaged
 - 24/7 Nurse Advice Line (above)
 - Health Coaching via Nurse Advice Line or Case Manager
 - Weight management support
 - Tobacco cessation support

Predictive Analytics: With timely access to medical claims, pharmacy claims, behavioral claim, benefits, lab values, etc., analytic tools are used to identify and stratify the risk for the beneficiaries. This is used to determine what programs might best suit the needs of the beneficiary.

Interdisciplinary Care Team (ICT): Input from member of the ICT, including the member, family/caregiver, primary care provider (PCP), pharmacists, specialists, home health agencies, and community resources inform the ICT of additional vulnerabilities and risk factors.

The provision of these programs requires that Cigna have access to timely and complete diagnosis information, the ability to outreach to the beneficiary, and the ability to coordinate with the provider.

Below we offer proof points from our experience with bringing these initiatives to a Medicare population through our Cigna-HealthSpring’s Medicare Advantage plans. It is important to note that these results would likely not be achieved in a Medigap population without a tightly managed network construct.

1. Chronic Care Improvement Program (CCIP)
 - Team of health care professionals with experience in the clinical management of beneficiaries with multiple chronic conditions and long-term complex medical and social support needs
 - Enrollment is based on identification of members through predictive modeling, prevalence rates, and co-morbidities in each population
 - Also via HRA results or by a beneficiary’s provider
 - Management and intervention is telephonic with home, office, or hospital face-to-face visits when necessary
 - Includes end-of-life support via palliative care or coordination to hospice care
 - Typically uses these metrics to monitor the success of its population health programs

Table 1. HealthSpring Medicare Advantage 2011 CCIP Program Improvements

| Inpatient Statistics | Baseline | 12 Months Post | 24 Months Post | % Reduction Statistic |
|-----------------------------|----------|----------------|----------------|-----------------------|
| Average Acute Admits / 1000 | 1,559 | 766 | 821 | -47% |
| Average ER Visits / 1000 | 986 | 766 | 651 | -33.9% |
| Total Cost PMPM | \$3,364 | \$2,594 | \$3,018 | -10.2% |
| PCP Visits Per 1000 | 0.75 | 0.72 | 0.73 | -2.6% |
| Specialist Visits Per 1000 | 0.88 | 0.85 | 0.89 | +0.01% |
| Scripts Per 1000 | 5.23 | 5.99 | 6.32 | +20% |

2. Congestive Heart Failure (CHF) Program
 - Case Manager would be assigned to individual to reinforce medication/dietary compliance
 - Target beneficiaries with the diagnosis of CHF that have an ejection fraction of <40%, new onset CHF and two or more hospitalizations in six months for CHF exacerbation

Table 2: Cigna-HealthSpring CHF Results (Texas)

| HEDIS Measure | 2009 Outcomes | 2010 Outcomes | 2011 Outcomes | Change |
|---|---------------|---------------|---------------|--------|
| CHF | | | | |
| Annual Monitoring for Patients on Persistent Medicines – ACE & ARBS | 87.7% | 90.10% | 94.57% | +6.87 |
| Annual Monitoring for Patients on Persistent Medicines – Diuretics | 87.5% | 90.70% | 94.33% | +6.83 |

3. Respiratory Disease Program
 - Home visit by a registered respiratory therapist (RRT)
 - RRT would complete questionnaire with beneficiary to help identify any gaps in knowledge about disease process and also identify any potential issues
 - Collaborate with provider, if needed
 - Designed for beneficiaries with a diagnosis of COPD, asthma, or emphysema with home respiratory equipment (O², nebulizer), and who have had two or more admissions, or with disease specific medications

Table 3: Cigna-HealthSpring Respiratory Disease Results

| | Program Inception (2009) | 8/1/2013 |
|-------------------------------------|--------------------------|--------------|
| MLR (%) | 176.63% | 97.88% |
| Total cost | \$3,388 pmpm | \$2,439 pmpm |
| Acute admissions per thousand (APK) | 1,988 | 1,091 |
| ER ADK | 998 | 807 |

4. Diabetes Program
 - Focus on beneficiaries with diabetes
 - Beneficiaries would be part of the Care Transition Coaching (CTC) program or under Complex Case Management dependent on risk level and utilization history

Table 4: Cigna-HealthSpring Diabetes Program Results

| HEDIS Measure | 2009 Outcome | 2010 Outcome | 2011 Outcome | Change |
|--|--------------|--------------|--------------|--------|
| Diabetes: | | | | |
| Comprehensive Diabetes Care: HbA1c Testing | 87.1% | 91% | 93.43% | +6.33 |
| Comprehensive Diabetes Care: LDL-C Screening | 86.9% | 91.24% | 91.97% | +5.07 |
| CDC-Monitoring for Diabetic Nephropathy | 86.4% | 91.97% | 92.94% | +6.54 |
| Comprehensive Diabetes Care: Eye Exam | 55.2% | 57.42% | 67.15% | +11.95 |

5. Depression Management Program

- Provide outreach and education to members, coordinate care with members’ PCPs, and identify members who might benefit from more intensive care coordination services through the Behavioral Health Community Based Care Coordination program.

Our programs are designed to work as a partnership among members, providers, and other health services staff and it is requisite that this coordination be allowed. If for any reason we were unable to partner with providers and health services staff, we would be unable to fully implement the programs outlined above.

The care coordination and case management programs are designed to target members according to their risk levels and needs. The level of service provided to members may vary based on member acuity but should not constitute differing levels of benefits. All programs are available to all members but would only be impactful to those meeting agreed upon criteria.

Understanding the above, there are three requirements for insurer participation:

1. Financial support to extend the current programs, and develop new ones where needed, to the Medigap membership
2. Reduced lag in claim activity to identify diagnoses that trigger outreach protocols as close to the claim as possible
3. Access to de-identified total claim activity for the Medigap population to identify the biggest total population drivers of cost

Finally, in order to run these programs most effectively, they must be run alongside the Medigap benefit and not be embedded in the product in order to allow for the flexibility to make changes and adjustments in the programs as the data warrants.

In the current Medigap model, carriers pay claims after they are incurred with little opportunity to impact the claim before it is incurred. In order to medically manage this population, we need to get ahead of some of the claims by identifying triggering diagnoses in a timely manner.

This is also a population that has had little-to-no care coordination, so there is the potential to impact cost and quality by reducing duplicate and unnecessary care. However, there cannot be barriers to collaborating with physicians and providers or else the outreach programs will not work.

Due to the structure of Medigap, CMS pays the bulk of claims – 80 percent – while the carrier is responsible for the balance. Thus the opportunity for savings will accrue largely to CMS. It will be important that the cost of providing the programs mentioned above does not outweigh the benefit to the carrier of providing those programs.