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Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Request For Information: IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors

Dear Office of the Assistant Secretary for Planning and Evaluation:

Anthem, Inc. (Anthem) appreciates the opportunity to respond to the Office of the Assistant Secretary for Planning and Evaluation's (ASPE) Request for Information (RFI) on the "IMPACT ACT Research Study: Provider and health plan approaches to improve care for Medicare beneficiaries with social risk factors."

Anthem is working to transform health care with trusted and caring solutions. Our health plan companies deliver quality products and services that give their members access to the care they need. With over 74 million people served by its affiliated companies, including nearly 40 million within its family of health plans, and 1.7 million Medicare consumers, Anthem is one of the nation's leading health benefits companies. For more information about Anthem's family of companies, please visit www.antheminc.com/companies.

Executive Summary and Overarching Comments

Anthem shares ASPE's commitment to identifying and implementing effective approaches to care for Medicare beneficiaries with social risk factors. As a committed participant in the Medicare Advantage (MA), Part D, and Medicaid programs, Anthem is working every day to improve health outcomes for beneficiaries by addressing Social Determinants of Health (SDoH). It is increasingly important that today's health programs are able to effectively account for social risk in order to not only close persistent gaps in health outcomes, but ensure accurate and meaningful quality measurement. As ASPE continues its work to assess the effect of Socioeconomic Status (SES) on quality measures and measures of resource use in Medicare, Anthem urges ASPE and the Centers for Medicare & Medicaid Services (CMS) to:

- ***Develop and Implement a Long-Term Solution for the Impact of Socioeconomic Status (SES) on the MA and Part D Star Ratings Program***

Beneficiary-level characteristics, specifically dual status and socio-economic factors, have a meaningful impact on Star Ratings and it is critical to enable plans that care for these beneficiaries to compete on a level playing field. The Categorical Adjustment Index (CAI) is insufficient to compensate plans caring for the most high-cost, high-need beneficiaries. CMS has acknowledged that the CAI has a very small impact on plan ratings. ASPE and CMS should continue working with plans to identify and evaluate a long-term, meaningful solution to address the impact of dual status and SES on Star Ratings since the CAI is only a temporary solution.

- ***Increase Supplemental Benefit Flexibility and Empower Beneficiaries to Select the Plan that Best Meets their Needs***

It is imperative that beneficiaries have the information they need to identify the plan that will provide the highest-quality care and most tailored benefits based on their unique needs. Additional support services and supplemental benefits can be particularly important for beneficiaries with social risk factors. However, the tools currently available to beneficiaries such as the Medicare Plan Finder (MPF) do not allow them to fully evaluate the value of different plan benefit options. To empower beneficiaries to take advantage of the new benefits that plans are able to provide, CMS must improve the resources available for beneficiaries to more accurately compare plans.

Additional flexibility for plans to better address social risk factors like homelessness and food insecurity is a critical tool for plans to attend to beneficiaries' social risk factors. It is critical that health plan benefits can address issues beyond a specific medical condition such as social supports. ASPE should recommend that CMS provide health plans with more flexibility in offering allowable supplemental benefits to expand supplemental benefit offerings to address to social risk factors.

- ***Help Facilitate Data Sharing and Collection***

In our experience, gathering complete and accurate data is an important first step to enhance care coordination and improve outcomes. CMS can play a crucial role in incentivizing and facilitating data collection and allowing for data-sharing between Medicaid programs and Medicare plans to ensure higher-quality care. Having more information about patients likely to need additional supports and services, such as the chronically ill and the dual-eligible populations, will help plans identify the most appropriate and effective steps to address SDoH.

Detailed Comments

Develop and Implement a Long-Term Solution for the Impact of SES on the MA and Part D Star Ratings

Beneficiary-level characteristics have a meaningful impact on Star Ratings and CMS plays a critical role in enabling plans that care for the program's most vulnerable beneficiaries to compete on a level playing field. However, in our experience, the CAI is insufficient to compensate plans caring for the most high-cost, high-need beneficiaries. Moreover, CMS has acknowledged that the CAI is a temporary solution that has a very small impact on plan ratings.

Thus, Anthem urges ASPE and CMS to continue working with plans to identify a long-term solution to the impact of dual status and SES on Star Ratings. Anthem appreciates the ongoing attention to and focus on the impact of beneficiary-level characteristics – specifically, dual status and socio-economic factors – on plan performance. We understand that the CAI is a temporary solution, and we support ASPE's work to fully evaluate proposals to develop a longer-term, meaningful fix. It is also critical to accurately account for social risk factors in MA through more meaningful data, quality performance measures, risk adjustment and value-based payment. A long-term solution that truly reflects the impact of dual status and SES on payment will recognize the unique challenges and outsized investment undertaken by plans who are committed to holistically serving dual eligibles and members with social risk factors.

Increase Supplemental Benefit Flexibility to Address Beneficiaries' SDoH

We appreciate the Administration's efforts to expand allowable health-related supplemental benefits. Anthem and its affiliated health plans are committed to offering plans that provide high-quality medical care and other social supports. For 2019, Anthem developed additional supplemental benefit options by asking beneficiaries' about their needs. At the request of beneficiaries, Anthem is offering the following supplemental benefits:

- **Assistive Devices**: Provides \$500 towards assistive devices such as shower stools, reaching devices, temporary wheelchair ramps, and more.
- **Personal Home Helper**: Provides an in-home health aide for caregiver respite, home-based chores, and activities of daily living (ADL) due to health issues not otherwise covered under any other Medicare benefit. Assistance can be provided for up to 124 hours of care in a calendar year (up to four hours per day for 31 days in a calendar year).
- **Healthy Food Deliveries**: Provides up to 16 meals per qualifying event, and allows up to four events each calendar year for 64 meals in total. A qualifying event may include post discharge from a hospital or other need if the beneficiary has a Body Mass Index (BMI) more than 25 and/or an A1C level more than 9.0.

- Pain Management: Provides up to a combined total of 24 medically necessary acupuncture and/or therapeutic massage visits each calendar year. Acupuncture and therapeutic massage participating providers must be licensed or certified, as applicable, by the state.
- Day Center Visits: Provides up to one visit per week for adult day center services. The center must be licensed by the state to provide adult day center services. To qualify beneficiaries must need help with two activities of daily living, and transportation to and from the center is covered.
- Transportation: Covers up to 60 one-way trips each calendar year to and from locations within the local service area when obtaining plan-covered services. Trips may be covered for getting to and from medical visits, SilverSneakers locations and visits to a pharmacy after a covered medical service.

Anthem recommends the Administration provide additional flexibility to plans to better address social risk factors. Currently, supplemental benefits cannot target health care services based on social determinants, like homelessness or food insecurity. However, in 2020 it may be possible for certain offerings to address issues beyond a specific medical condition, such as social supports. ASPE should recommend that CMS provide health plans to have more flexibility in allowable supplemental benefits, and expand supplemental benefit offerings to cover additional services, such as pest control and over the counter items, that will address social risk factors, help beneficiaries manage medical conditions and improve their overall health status.

Empower Beneficiaries to Select the Plan that Best Meets their Needs

Anthem shares CMS' commitment to continuously identifying and implementing innovative approaches for empowering beneficiaries to make the best health care decisions for their unique needs. The MPF is an important tool that seeks to enable beneficiaries to identify, compare, and enroll in the Medicare plan that best meets their needs. By enhancing this tool, CMS would help provide beneficiaries with the information needed to facilitate enrollment in high-value health coverage.

However, aspects of the MPF fails to provide beneficiaries with a tool to holistically and accurately compare annual health care costs.¹ A recent qualitative study of the MPF reported beneficiaries found it difficult to assess the value of health plans and raised concerns about the predictive modeling of current beneficiary cost calculations. This issue is particularly problematic given that most beneficiaries report out-of-pocket costs are the most important consideration when choosing a plan, but do not understand the cost information on MPF.²

¹ Medicare.gov. Out-of-Pocket Costs (OOPC) Data Calculations. Available at: <https://www.medicare.gov/find-a-plan/staticpages/oopc-calculations.aspx>

² NCOA. Modernizing Medicare Plan Finder. Available at: <https://www.ncoa.org/wp-content/uploads/CC-2018-MedicarePF-Report-Final-0418.pdf>

Today, Medicare plans are sorted by lowest estimated annual health and drug costs based on Out-of-Pocket Costs (OOPC) data calculations that fail to educate beneficiaries on newly allowable supplemental benefits. The actuarial impact of the OOPC data calculations are inadequate because the model fails to account for the full richness of benefit designs and puts high-value health plans with robust supplemental benefit offerings at a placement disadvantage. A lower placement on the MPF makes it more difficult for beneficiaries to choose a health plan that offers affordable benefits that improve their health outcomes and lower their out-of-pocket costs.

CMS granted health plans additional flexibility to offer supplemental benefits that can enhance quality of life and improve health outcomes. By redefining health-related supplemental benefits, CMS has allowed plans to more holistically address the health care needs of Medicare consumers, which can lead to improved outcomes, reduced out-of-pocket costs, and decreased system-wide costs. Anthem implemented supplemental benefit flexibilities to better meet beneficiaries' health care needs. However, the MPF currently fails to value these benefits appropriately or list the available supplemental benefits.

As Anthem has expanded supplemental benefit offerings, the lowest estimated annual health and drug cost ranking based on the OOPC calculations has forced these health plans lower in the MPF options, making it less likely beneficiaries will obtain flexible, high-value supplemental benefit offerings that address social risk factors. Weighting comprehensive dental supplemental benefits, while failing to capture the benefits Anthem has added such as transportation to incentivize preventive care, assistive devices such as grab bars to prevent falls, and in-home health to help avoid hospital readmissions is a methodological limitation of the OOPC estimates that should be rectified.

ASPE should encourage CMS to improve beneficiary cost calculations and redesign MPF comparison and decision support tools to ensure beneficiaries can consider the full spectrum of health plan offerings. At a minimum, CMS should accurately display newly allowable supplemental benefits. The unintended operational consequences of expanding allowable supplemental benefits should be addressed, particularly as additional guidance that could improve social barriers to care is released re-defining supplemental benefits in 2020 and beyond.

Sharing Data would Benefit the Coordination of Services for Dual-Eligibles, Including Those with Social Risk Factors

As ASPE recognizes in its RFI, comprehensive data collection is an essential tool in ensuring that the needs of beneficiaries, including their social needs, are holistically addressed. This is particularly important for dual-eligible beneficiaries, since their data are captured by providers and health plans who participate in both the Medicare and Medicaid programs. Therefore, coordination between data systems is key to improved health outcomes of these high-cost, high-need beneficiaries.

In our experience, the dual-eligible population faces a number of challenges, including social risk factors that can make it difficult for providers and plans to provide proactive care. For example, dual-eligible beneficiaries may frequently change addresses or phone numbers, which means that providers and plans may have out-of-date contact information for these patients and cannot reliably reach them to remind them to attend appointments. More integrated data systems and coordination between Medicaid and Medicare plans can help minimize the chances that member information is out of date. As ASPE and CMS consider ways to improve data sharing between the Medicare and Medicaid programs for this highly complex population, avoiding undue SNP program administrative requirement burden is essential, so that resources are not diverted away from necessary services and care coordination.

Anthem's experience with Medicare-Medicaid Plans (MMP) has illustrated the important relationship between SDoH and behavioral health. Beneficiaries with serious mental illness have a higher rate of comorbidities, and higher health care costs.^{3 4} CMS data shows forty-one percent of dually eligible beneficiaries have at least one mental health diagnosis, while 68 percent have three or more chronic conditions.⁵ Data is critical for the early identification of behavioral health challenges to deliver mental health treatment and improve outcomes for dual eligible beneficiaries.

Anthem recommends that MMPs and Dual Eligible Special Needs Plans (D-SNPs) routinely receive updates on Medicaid coverage by carrier from state agencies. Further, Anthem suggests that states develop data collecting mechanisms and disseminate this information to the relevant health plans in a consistent manner, leveraging existing reporting and data sharing platforms.

In addition, it would be helpful to D-SNPs to have historic Medicaid claims data from other carriers in order to provide a more complete picture to the case management team and assist with improved coordination of care for dual eligibles with complex health care needs and social risk factors. Ideally, this type of data would be sent to plans at consistent intervals. This would provide a more complete picture of historical social risk factors and assist health plans in better serving dual-eligible beneficiaries and coordinate services and supports. With a clear and complete view of the data, plan sponsors can serve as the best advocate for the member by coordinating care and social supports.

Increase Support for Effective Approaches to Link Unmet Social Needs and Care Management

In its RFI, ASPE identifies four key strategies and interventions for MA plans addressing social needs, including needs identification and targeting; care management and coordination; directly addressing

³ M. De Hert, C.U. Correll, J. Bobes, M. Cetkovich-Bakmas, D. Cohen, I. Asai, et al. "Physical illness in patients with severe mental disorders: Prevalence, impact, of medications and disparities in health care." *World Psychiatry*, 10 (2011): 52-77.

⁴ C. Boyd, B. Leff, C. Weiss, J. Wolff, A. Hamblin and L. Martin. *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*. Center for Health Care Strategies. December 2010. Available at www.chcs.org.

⁵ Medicare-Medicaid Coordination Office, National Profile 2012. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-CoordinationOffice/Downloads/NationalProfile_2012.pdf

social needs; and integration of Medicare and Medicaid. We are already implementing several of these strategies as outlined in examples below and urge ASPE to leverage Anthem's experience as a leader in effective care management for beneficiaries' with social risk factors.

America's 1st Choice

America's 1st Choice is an Anthem affiliated Medicare Advantage organization that offers HMO products, including Chronic Special Needs Plans (C-SNPs) and D-SNPs, under its Freedom Health and Optimum brands in Florida. The plan also operates America's 1st Choice of South Carolina, and currently serves approximately 135,000 Medicare consumers in 25 counties in Florida and three counties in South Carolina.

America's 1st Choice serves dually eligible beneficiaries through a D-SNP with zero-dollar co-pays for primary, specialist, and mental health services. The D-SNP plans offer rich transportation benefits to facilitate access to care. D-SNP beneficiaries' can also receive monthly over-the counter allowances from \$20 to \$50 each month. Additional benefits like transportation, meals post-hospitalization, and over-the-counter supplies help America's 1st Choice stay in touch with beneficiaries' and deliver care that can help manage chronic conditions and prevent emergency room visits.

One strategy to achieve cost savings and improvements in quality care for vulnerable beneficiaries is care management. The health plan utilizes social workers to better attend to the needs of beneficiaries' with social risk factors. Questions have been added to the America's 1st Choice Medicare Health Assessment Tool and Disease Management Screening Tool to help identify members who feel unsafe, require assistance with activities of daily living and face financial challenges. The social workers identify the highest need beneficiaries and coordinate necessary care, review plan benefits, encourage member engagement with their primary care provider, and inform members of community resources. Social workers also help members apply for financial assistance, and engage with designated care givers to help beneficiaries navigate the health care system and improve health outcomes.

HealthSun

HealthSun is an Anthem affiliated integrated Medicare Advantage health plan and health care delivery network in Florida. HealthSun serves more than 40,000 MA consumers in Miami-Dade and Broward counties through its network of 19 wholly-owned primary care and specialty centers. The health plan population is approximately 83-84 percent dual eligible and/or low-income subsidy.

Providing non-emergency transportation for low-income populations is a cost-effective way to improve life expectancy and quality of life.⁶ HealthSun understands that transportation benefits enable dually

⁶ P. Hughes-Cromwick and R. Wallace, et al. Cost Benefit Analysis of Providing Non-Emergency Medical Transportation (2005). Available at: https://altarum.org/sites/default/files/uploaded-publication-files/05_project_report_hsd_cost_benefit_analysis.pdf

eligible beneficiaries to obtain necessary primary, specialist, dental, and vision care. Through an extensive network, the plan is able to provide transportation benefits to enable members to access care at wholly-owned clinics and a broad segment of provider network clinics.

Physical activity is key element of health and wellness. Every 11 seconds, an older adult is treated in an emergency department for a fall-related injury and a growing population of older adults are vulnerable to social isolation.⁷ Primary and specialty care visits incorporate time at wellness centers in the HealthSun network. These centers can provide classes from SilverSneakers, social activities like bingo, classes on chronic diseases such as diabetes and even healthy meals. The wellness centers reduce social isolation and hunger, while increasing beneficiaries' physical activity.

In 2019, HealthSun is adding a personal home care benefit for eligible members who have been hospitalized and discharged from an acute or non-acute setting to their home. The benefit will provide up to 16 hours of home care aid twice annually to assist beneficiaries with general activities of daily living to prevent readmissions. Members recently discharged from the hospital may also qualify for a meal service from the Independent Living System, which provides a limited number of days' supply of prepared food delivered to the home.

Social risk factors such as homelessness, income insecurity, and hunger are consistent issues that the health plan is able to better address through benefit flexibility. Dually eligible HealthSun members benefit from over-the-counter benefits for pharmacy related items that may include tooth brushes, tooth paste, and non-prescription medications through additional assistance in Miami-Dade and Broward Counties. Telehealth has also been utilized as a behavioral health benefit for members with social risk factors. However, limited access to technology often prevents vulnerable populations from accessing educational resources which is why it's critical that health plans can leverage additional resources to address beneficiaries' social barriers to care.

CareMore

Individuals enrolled in certain Anthem MA plans receive their health care through CareMore, an integrated care delivery system for Medicare and Medicaid patients. Founded in 1993, CareMore serves 100,000 Medicare and Medicaid beneficiaries across eight states. The three pillars of the CareMore Health model for innovative health care delivery focus on care management:

- Chronic care management: Employing "extensivists," who are highly-trained doctors who understand all aspects of medical care and coordinate care across multiple doctors, specialists, and treatments for patients with chronic conditions and other complex health needs;

⁷ National Council on Aging (2018) Falls Prevention Facts. <https://www.ncoa.org/news/resources-for-reporters/get-the-facts/falls-prevention-facts/>

- Acute care management: Acting quickly and effectively when a patient needs care and ensuring proper follow-up protocols are adhered to by patients and doctors; and,
- Predictive modeling and early intervention: Identifying where risk lies for patients and patient groups and creating innovative ways to mitigate that risk.

CareMore beneficiaries face a number of risk factors that pose barriers to care. For example, many beneficiaries may experience housing instability and/or transience; lack of mental health related services and supports; limited English proficiency; low income/poverty status; and low health literacy or education level, among other risk factors. However, the CareMore model is specifically designed to target high-risk, chronically ill patients through focused care coordination, patient education, and proactive disease management. Through these efforts, CareMore has achieved costs 18 percent below industry average,⁸ while maintaining or improving quality of care.⁹

CareMore beneficiaries regularly meet with social workers who conduct needs assessments and connect them with health-related benefits and Community-Based Organizations (CBOs) to address their needs. For example, lack of transportation is a major barrier to accessing care. Every year, 3.6 million Americans miss or delay medical care due to their inability to access transportation services.¹⁰ Research shows that lack of transportation can reduce use of preventive and primary care¹¹ while encouraging use of the emergency department.¹² Recognizing this barrier, CareMore has partnered with Lyft to ensure that patients do not miss important medical appointments because they do not have reliable transportation. Through its partnership with Lyft, CareMore has delivered more than 300,000 trips per year across a population of about 85,000 Medicare members.

CareMore also recognizes the importance of wellness. Accordingly, dieticians have long been part of the care team. Additionally, there are Nifty after Fifty gyms located adjacent to CareMore facilities, providing patients easy access to fitness and movement. CareMore partners with gyms through the Prescribed Fitness program in which providers “prescribe” exercise to patients with chronic diseases such as diabetes. In this program, a member with diabetes could be written a “prescription” for exercise by their doctor during an appointment. After doctors’ appointment, the member will meet with a case manager, who will “fill” the member’s prescription for exercise by working one-on-one with her to create an exercise plan.

⁸ Main, T and Slywotzy, A (2011) The Quiet Health-Care Revolution. The Atlantic.

<https://www.theatlantic.com/magazine/archive/2011/11/the-quiet-health-care-revolution/308667/>

⁹ Clear Choices Campaign and National Council on Aging (2018). Modernizing Medicare Plan Finder: Evaluating and Improving Medicare’s Online Comparison Shopping Experience. <https://www.ajmc.com/journals/ajac/2015/2015-vol3-n2/lessons-from-caremore-a-stepping-stone-to-stronger-primary-care-of-frail-elderly-patients?p=2>

¹⁰ <http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTpaper.pdf>

¹¹ Adolescents who use the emergency department as their usual source of care. Wilson KM, Klein JD. Arch Pediatr Adolesc Med. 2000 Apr; 154(4):361-5.

¹² The effects of access to pediatric care and insurance coverage on emergency department utilization. Johnson WG, Rimsza ME Pediatrics. 2004 Mar; 113(3 Pt 1):483-7.

CareMore is also a leader on addressing the senior loneliness epidemic in the United States. Studies show that loneliness can potentially increase a person's risk of mortality by 45 percent – more than air pollution, obesity, or excessive alcohol use.^{13,14} Eighteen months ago, CareMore introduced the Togetherness Program, a comprehensive initiative aimed at identifying and addressing in the loneliness among its senior patients through weekly phone calls, home visits, and encouragement and connection to community-based programs. The Togetherness Program is a first-in-industry clinical approach to address senior loneliness as a treatable condition by focusing on patients' psychological, social and physical health. Participants in the Togetherness program increased engagement with Nifty after Fifty gyms by 53 percent. Additionally, despite a higher disease burden among program participants, emergency department use has declined by 5 percent among program participants, and acute admissions are 11 percent lower per thousand as compared to non-participants.

CareMore also partners with CBOs in their local markets to provide patient linkages to social supports in the community setting. In each CareMore market, the social work team maintains a list of local organizations that can provide important social services. The teams make sure the list is up-to-date and that patients have access to services. For example, during patient assessments, social workers may identify a patient need, such as housing insecurity, and refer the patient to a local housing organization on their list of CBOs for assistance.

CareMore is constantly striving to improve its ability to quickly and efficiently connect its members with the services they need, and its data-driven approach for identifying patients with social risk factors helps CareMore continue to reach out to members as proactively as possible. CareMore is in the process of rolling out a customized, member-specific screening tool that will get to the core of how CareMore practices medicine. The tool maps to the eight domains of SDoH that will be a resource to providers as they work directly with patients to identify potential risks and barrier to care. For example, a provider will routinely ask a member if he is experiencing food insecurity. If the member says yes, the tool will provide a framework of follow-up questions to help the provider understand the nature and causes of the challenges the member is experiencing. This tool will be loaded into providers' Electronic Health Records (EHRs) to allow for uniform implementation and utilization across CareMore facilities.

Collection of complete and accurate data, like the provision of comprehensive care, requires that providers are able to spend enough time with each patient. The primary barrier to collecting data about social risk factors is provider time. For example, CareMore providers would like to spend at least 45 minutes with each patient to gain a full understanding of their needs and to build trust with the patient. However, under the current system, providers struggle to spend enough time with each individual patient to identify unmet social needs.

¹³ Holt-Lunstad J, Smith TB, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-analytic Review. *PLoS Med* 7(7): e1000316.

¹⁴ Perissinotto C, Cenzer I, Covinsky K. Loneliness in Older Persons A Predictor of Functional Decline and Death. *Arch Intern Med.* 2012; 172 (14): 1078-1084

Increase Electronic Health Record Interoperability

EHR interoperability is a cornerstone of delivering state of the art medical care, providing opportunities to enhance patient satisfaction and enable data sharing. Despite recognition of the importance of interoperability, it has been widely documented that that EHR systems are fractured and siloed, and that more work is needed to effectively exchange of health information. Additionally, many key stakeholders are unwilling to share data with perceived competitors and engage in “data blocking,” making it difficult for payers, health care providers, and even patients to access patient data.

Anthem is seeking ways to build trust between payers and providers and promote EHR interoperability. For example, in 2014, Anthem partnered with seven competing health systems in California to create the integrated Anthem Blue Cross Vivity. As part of this initiative, clinical EHR data is shared between health systems, creating a patient-centered approach that closes care gaps and promotes health outcomes.

Recent efforts, like the administration’s MyHealthEData and the overhaul of the Quality Payment Program to focus on “Promoting Interoperability”, may remove barriers to data sharing, and we appreciate the administration’s focus on this important issue. However, we urge ASPE and CMS to continue to promote collaboration among payers and appropriate information sharing – missing and lagged data prevents providers from developing a truly patient-centered approach to managing care and addressing social risk factors.

Advance Telehealth and Telemedicine

Anthem supports the use of telehealth and telemedicine to identify and address social risk factors. We believe that meeting the patient where they are will help ensure robust access to care, improve efficiencies, expand disease management programs, assist in transitional care activities/coordination of care amongst the Medicare population, and drive improvements in patient experience. Moreover, telehealth has the ability to empower patients and caregivers, while improving the lives of beneficiaries. Telehealth can bridge geographic, time, and mobility gaps between patients and their health care providers.

For patients with social risk factors, particularly those with limited ability to ambulate, telehealth is a best practice. Through telehealth, Anthem is meeting patients where they are. Anthem recognizes that CMS is considering how best to incorporate telehealth into benefit packages and how to incentivize the provision of telehealth. However, we believe that more steps need to be taken to ensure that beneficiaries can access cutting edge technologies to improve health outcomes.

ASPE should encourage CMS to improve network adequacy review processes and increase flexibility for time-and-distance standards to facilitate greater use of telehealth services among Medicare beneficiaries. Anthem recommends CMS streamline and improve the network adequacy review process,

including allowing plans to use telehealth to meet adequacy requirements in certain situations to better address health care needs and social risk factors. In CY 2018, CMS began allowing organizations to request an exception if they are using a telehealth or a mobile provider to meet network adequacy requirements. CMS will consider this type of rationale on an Exception Request only for Counties with Extreme Access Considerations (CEAC), Rural, or Micro county types. However, additional guidance and flexibility in the Exception Request process is needed.

CMS' current emphasis on time-and-distance standards can often be overly prescriptive and ultimately limit sponsors' ability to serve certain geographic areas and harder-to-reach members. Flexibility related to the types of providers who satisfy time-and-distance requirements would be helpful. For example, many primary care providers can support certain behavioral health needs, in addition to general medicine, but they have more distinct time-and-distance requirements they must meet than behavioral health providers.

Anthem is committed to ensuring that Medicare beneficiaries have access to quality health care, as evidenced by our long-standing relationship with the National Council on Aging (NCOA), with whom we are partnering through NCOA's Benefits Checkup and Aging Mastery Programs. Most recently, with support from the Anthem Foundation, Anthem awarded a grant to NCOA to meaningfully expand their Aging Mastery Program to thousands of older adults across five of the states where Anthem operates. The program addresses social determinants of health and removes barriers for Medicare beneficiaries that stand in the way of accessing quality health care and living more healthy and active lives.

Anthem appreciates this opportunity to provide input on this RFI and welcomes the opportunity to discuss our work and recommendations. Should you have any questions or wish to discuss our comments further, please contact Danielle Horne at 818.298.7830 or Danielle.Horne@Anthem.com.

Sincerely,



Anthony Mader
Vice President, Public Policy