ACAP
Association for Community Affiliated Plans

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Jonathan Blum
Director
Center for Medicare
Center for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore MD 21244-1850

Submitted electronically to: AdvanceNotice2013@cms.hhs.gov

Dear Mr Blum and staff:

The Association for Community Affiliated Plans (ACAP) appreciates this opportunity to provide comments in response to the Advance Notice of Methodological changes for calendar year (CY) 2013 for Medicare Advantage (MA) Capitation Rates, Part C and Part D payment policies and the2013 Call Letter.

ACAP is an association of 57 not-for-profit and community-based health plans. Our member plans provide health coverage to nearly 10 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans (SNPs) for people who are concurrently enrolled in Medicare and Medicaid (dual eligibles). Nationwide, ACAP plans serve nearly one of every three Medicaid managed care enrollees. Approximately half our plans operate Dual Eligible SNPs and several also offer MA plans. Our comments follow in order of the Advance Notice and the Call Letter.

ADVANCE NOTICE

Risk Adjustment Section F. CMS-HCC Risk Adjustment Model (p13)

We understand that CMS is recalibrating the model with data from the more recent years of 2008 and 2009, but not making any other changes. We continue to be concerned about the risk adjustment for full benefit duals that are under 65 and those duals with advanced age, frailty and /or advanced stages of illness. How is CMS approaching the language in the ACA which asked for further refinement of the underlying model.
We repeat these comments from our response last year,*" the entire risk adjustment system provides a smoothing of risk that arises in the randomness of enrollment in very large plans. Yet, it may not work as well for smaller plans who seek enrollment of higher risk individuals. We note that in explaining the current risk adjustment system, Bianca K. Frogner, PhD, Gerard F. Anderson et al in a recent article in Medical Care report that "The risk adjustment model is based on the work originally done by Pope et al and then modified by CMS. The current model uses hierarchical condition categories (HCCs) that map all ICD-9-CM diagnosis codes into 189 distinct condition categories…. Ultimately, CMS decided to use only 70 of the 189 condition categories, arguing that the more parsimonious model predicted almost as well as the full model." Since this decision was made in 1999, SNPs were developed to serve individuals that have more specialized needs. Has CMS reviewed the excluded diagnoses to see if using the smaller number still works as well in this different enrollment model?"*

Can CMS comment in the final Call Letter as to whether this is still the approach? Does the limited use of HCCs work for the more specialized plans?

On January 30 Melanie Bella of The Office of Medicare –Medicaid Integration released information which announced that they had newly "tagged" 13 conditions in the chronic condition warehouse to make better use of the underlying Medicare data . In her memo she wrote, *"The flags were the product of newly developed algorithms to identify additional conditions to be flagged for beneficiaries. These algorithms have been applied to both Medicare and Medicaid claims for 2006 and 2007 data—resulting in a flag for Medicare, Medicaid and Medicare-Medicaid enrollees. The conditions identified by this panel include 13conditions which are primarily mental health and behavioral health related.*

Were these conditions "tagged" in the 2007 data used for the risk adjustment update? If not, how does CMS use these conditions in its HCC model?

Section H. New Enrollee Risk Scores for Chronic SNPs (page 14)
As we mentioned in our comments to the proposed regulations, the new enrollees in D-SNPs need the same type of adjustment. CMS should use previous health claims from Medicaid for those new to Medicare who are under age 65. Data that was used to establish the basis of disability would also be available from SSA. Plans need a risk adjustment method for high need individuals that has a more prospective, rather than retrospective, risk adjustment approach. We urge CMS to conduct an analysis of those SNPs which served primarily the under 65 dual eligible and terminated their status due to insufficient payments for the members. Former members of those plans could also serve as a good focus group to describe the benefit they received from the plan and the transition issues they faced.

Section J. Frailty Adjustment (page 17)
ACAP supports a "money follows the person" approach and urges recognition of the needs of frail persons to the greatest extent possible. Plans in states that have large scale enrollment of duals in SNPs are disadvantaged compared to those in states which enroll the nursing home-certifiable duals in separate plans. CMS should consider recognizing state assessments of frailty for FIDESNPs as an alternative to other surveys. We urge a study of the underlying risk adjustment system to adequately recognize frailty. It appears that the current model may disadvantage duals and plans in states which rely more on community based, rather than nursing facility care, for its population. We also urge further study by CMS of the cross-payer effects on MA/SNP payment when states offer robust Home and Community Based services. Something is not working well here …whether it is the frailty calculations or some other approach, we ask for some deeper analysis of getting payment better aligned with the risk of the member.

We also think the definition of FIDESNSP as applied should recognize state policy on the integration approach. For example, we understand that D-SNP plans in Minnesota may not meet the FIDESNP measure because there is a 180 day stop-loss provision on the nursing benefit. Plans still coordinate services, but the state pays the facility directly after six months. We consider that these Minnesota plans (legacy plans in the integrated care world) are a good example of fully integrated plans.

CALL LETTER

Enhancements to the Plan Ratings (page 60-70)
We submitted comments in January on the quality areas and ask that those comments also be considered as part of this submission. We support the changes in the call letter to move some measures to display status.

We continue to strongly advocate risk adjustment of the measures and a comparison of quality between matched cohorts of fee-for service duals to those in the SNPs. And, we ask that SNPs not be compared to MA-PDs unless it is with enrollees in MA-PDs with matched health, functional and social and economic factors.

We ask further for study of CAHPS especially for Dual Eligibles when a plan's raw score is adjusted downward for the positive responses of dual eligibles. Duals in fully integrated plans or in Dual SNPs may truly appreciate the care management and reduced paperwork they experience from a plan.

Contracting Organizations with Ratings Less Than Three Stars in Three Consecutive Years
We request that CMS work with states in developing any notices to duals in Dual SNP plans with less than three stars since all these plans will have a state contract. It should be remembered that all duals have ongoing "special election periods" so a notice about SEPs to duals is not all that meaningful. We also urge that until CMS has truly examined risk adjustment for the plan ratings, there should be careful review of plans with highly specialized populations who do not score as well on metrics that were originally developed for an employed population. Termination of a dual SNP should not be done in a rigid, hands-off way from the members' perspective. An assessment is needed as to whether those people would really be better served in fee-for service rather than in the current plan.

We support passive enrollment into an MA plan offered by the same organization as one way to smooth that transition. The fact that there are qualified MA plans in the same organization with sufficient star ratings seems to verify that there is something wrong with the assessment in Stars for the SNPs. Disparities that are hidden by virtue of a person being in a large plan rather than a highly specialized plan may "look " better on the Plan Finder, but it does not mean that the person is better served.

We urge that the Part C staff look at the work that the National Quality Forum is developing for appropriate measures for Dual SNPs.

Supplemental Benefits and Enhanced Disease Management (pages 77 to 80)

These two sections were confusing and need clarification in the final Call Letter. And if the intention is to add to the requirements imposed on SNPs, we strongly object to one more punitive approach that will make SNPs non-viable. We believe CMS should be actively engaging with those plans which are willing to serve a high- risk population to support the activities that can reduce deep, underlying health disparities. Just look at the most recent Health Affairs article by Deputy Secretary Koh, former administrator Berwick et al on health literacy as a challenge to health care cost, outcomes and patient experience. Pages 77-79 contain a good discussion of the care management role of plan. However, it appears beginning on page 80, that a NEW requirement is imposed on SNPs for an enhanced disease management "mandatory, supplemental benefit" that goes way beyond the SNP Model of Care and appears to be developed on a single disease model not a chronic care approach. This model is expensive and certainly not recognized in the bid model.

And, it does not recognize psycho-social models and new care management approaches that use peer support and community workers to support care management. This is an extremely prescriptive approach.

Our plans found this section VERY confusing. We hope that we are mis-interpreting this section and that there is no new requirement imposed on SNPs in this section.

Special Needs Plans (pages 85-91) Benefit Flexibility
This authority appears quite narrow and it is hard to see how many plans will know by March 2 whether they wish to utilize this option. We are also not sure how cost sharing would be imposed on duals.

Marketing Flexibilities for SNPs
We urge CMS to allow the marketing and materials alignment that were allowed in the original demonstration states to Dual SNPs with a state contract. In general,

State Role in Marketing Plan Sponsors" Products (page 92)
The word "marketing" has an implication that may cause confusion to the public. We support clarification that states have the right to provide information on available plans for beneficiaries without CMS approval.

Capitated Financial Alignment Demonstrations (page 94)
We expected to see more information in the draft call letter as per the January roll-out of this initiative. More information is definitely needed on the transition of D-SNPs in the demonstration states.

Thank you for the opportunity to share our concerns. ACAP is prepared to assist the agency with additional information as needed. If you have any additional questions please do not hesitate to contact Mary Kennedy, ACAP's Vice President for Medicare and Managed Long Term Care, at (202) 701-4749 or mkennedy@communityplans.net

Sincerely,

Margaret A. Murray
Chief Executive Officer