ACAP
Association for Community Affiliated Plans

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Ms. Deondra Moseley
Centers for Medicare and Medicaid Services
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Baltimore, Maryland 21244

Submitted electronically via AdvanceNotice2012@cms.hhs.gov

Re: Medicare Program: Comments on Part C/D Advanced Rate Methodology and 2012 Call Letter

These comments are submitted on behalf of the Association for Community Affiliated Plans (ACAP), an association of 54 not-for-profit and community-based Safety Net Health Plans.[1] Our member plans provide coverage to over 7 million individuals enrolled through Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dual eligibles. Almost half of our plans operate Special Needs Plans. Nationwide ACAP plans serve one of every four Medicaid managed care enrollees. We see our emerging role with SNPs as consistent with the primary mission to serve Medicaid beneficiaries. Many of the dual eligibles served by our plans were enrolled with our plans for their Medicaid benefits prior to becoming dually eligible. ACAP plans appreciate the opportunity to comment on the Advanced Rate Methodology and Call Letter and are especially pleased about the opportunity to comment on the needed transformation of SNPs for 2013.

Our comments follow the structure of the notice.

Attachment I. Preliminary Estimate of the National Per Capita Growth Percentage for Calendar Year 2012

We were pleased that the President's budget for 2012 proposes funding for a two year fix to the cut in physician rates and makes the assumption that a permanent solution will be found. Part C rate methodology should be based on the same assumption that no cut will be made to physician rates. Plans which serve dual eligibles have to structure their bids to arrive at a zero premium amount. The other adjustments made to rates in MIPPAA and the Affordable Care Act make this increasingly difficult. It is the beneficiaries who suffer when fewer dollars are available for rebates. We urge that CMS resume its previous practice of assuming that the Congress will act prior to the upcoming plan year and the physician cuts will not occur.

[1] ACAP represents safety net health plans that are exempt from or not subject to federal income tax, or that are owned by an entity or entities exempt from or not subject to federal income tax, and for which no less than 75 percent of the enrolled population receives benefits under a Federal health care program as defined in section 1128B(f)(1) (42 USC 1320a-7b(f)(1)) or a health care plan or program which is funded, in whole or in part, by a State or locality (other than a program for government employees).

Attachment II. Changes in the Payment Methodology for Original Medicare Benefits for CY 2012

Quality Bonus Payment Demonstration
As we stated in our response to the proposed regulation, we are very concerned that the Stars Quality System is not risk-adjusted and not ready to be used as part of the payment system. Therefore, we are very supportive of the demonstration and of the proposal to further incent more rapid and larger year-to-year quality improvement by applying the demonstration Quality Bonus Payments to the entire blended county rate for 3, 3.5, 4 and 4.5 star plans, in addition to the blended county rate for 5 star plans. We think CMS should go further and risk- adjust the data so that year-to-year improvement can be seen in reducing disparities in keeping with HHS' goals in that area.

This week's release of HHS' Agency for Healthcare Research and Quality (AHRQ) *2010 National Healthcare Quality Report* and *National Healthcare Disparities Report* finds that *"few disparities in quality of care are getting smaller, and almost no disparities in access to care are getting smaller. Overall, blacks, American Indians and Alaska Natives received worse care than whites for about 40 percent of core measures. Asians received worse care than whites for about 20 percent of core measures. And Hispanics received worse care than whites for about 60 percent of core measures. Poor people received worse care than high-income people for about 80 percent of core measures."* With the majority of duals in unmanaged fee for service, there should be recognition for plans willing to tackle these disparities. In this context, it is inappropriate to rate and rank plans with no regard for the underlying risk and disparity of the enrolled population.

SNPs are required to meet additional standards and have higher quality reporting requirements than other MA plans. Yet the payment system provides *no* credit in awarding stars for complying with those quality requirements. We urge CMS to award a partial star for the additional quality reporting by SNPs and a full star to top performers in those areas and work through the demonstration period to further refine how SNPs should be evaluated.

Risk Adjustment
The advanced notice confirms that in the 2011 Announcement, CMS indicated that it intended to implement an updated version of the CMS-HCC risk adjustment model in 2012. However, in the 2012 notice CMS is proposing not to implement the new model for Part C for 2012 in order to minimize change during 2012, the first year of the blended benchmarks under the Affordable Care Act**.**

It is not clear if CMS believes the risk adjustment system proposed does not work under the blended system or whether there is simply too much work involved in implementing the other changes. In any case, 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?*

As we mentioned in our comments to the proposed regulations, 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.

The notice later indicates that "CMS is currently conducting an analysis of the risk adjustment system, as required under section 1853, and will publish our results in the 2012 Rate Announcement, to be published April 4, 2011." Does this mean that regardless of what the analysis shows no change will be made until 2013?

<u>Frailty Adjustment</u>
ACAP supports a "money follows the person" approach and urges recognition of the needs of frail persons to the greatest extent possible. We would not like to see plans in states that have large scale enrollment of duals disadvantaged compared to those in states which enroll nursing home certifiable duals in separate plans from other duals. CMS should look also recognize state assessments of frailty for integrated approaches.

<u>Normalization Factor</u>
The influx of baby boomers begins in 2011 and increases in 2012. Because these new younger Medicare beneficiaries may have lower than average risk scores, the impact on overall gross coding trend for both FFS and Medicare Advantage plans may be lower than past years. Has CMS considered this when setting the normalization factor for 2012? Based on past documentation, the coding trend has been based solely on hindsight analysis and this hindsight analysis coincides with a period of time when the number of new Medicare beneficiaries was artificially low due to low births during the depression and war years of 1942-1945. The increase in the normalization factor between 2011 and 2012 is actually greater than in most years, going from 1.058 to 1.079. *Since prior to this year, normalization factors have typically increased by 1.4-1.5% per year, this year's increase in the normalization factor in some ways represents a rate cut of about 0.5% to 0.7% above and beyond the benchmark cuts.*

Attachment III- Changes in Methodology for Part D

<u>De Minimis Premiums</u>
We support this approach. For plans that target the low income premium subsidy levels in their bids, please allow greater freedom to make premium concessions to allow plans to meet the low income premium target.

Part D Risk Corridors
ACAP supports the risk corridors proposed.

Attachment IV and V – No comments

Attachment VI - 2012 Call Letter

Proposed Initiative to Promote Enrollment in Fully Integrated Dual SNPs
As mentioned at the beginning of this letter, ACAP is thrilled to see a recognition that something must be done to better align Medicare and Medicaid to serve dual eligibles. Given the very short timeline for this response, we trust this is the beginning of a dialog to promote better care for duals through plans which can integrate care across the domains of acute, chronic behavioral and long term care as well as across the Medicare and Medicaid programs. SNPs ,as they have been implemented within the larger MA program, have not been the right means to properly align the Medicare and Medicaid programs like the dual demonstrations in Minnesota, Wisconsin and Massachusetts and bring those approaches to a meaningful scale.

To begin the dialog, we will simply list ideas after each of the questions in the Call Letter.

1. *What criteria should be used for a SNP to be considered high quality?*
    - A model of care and care management system which focuses on the member's care preferences, which improves or maintains functioning and which manages transitions across settings and stages of illness
    - A network which includes essential community and safety net providers
    - The capacity to integrate mental health and long term supports and services with the acute care system
    - Effective focus on chronic care and the ability to coordinate multiple chronic illnesses
    - Adoption of medical home or the new health home model within the plan
    - Beneficiary and community members on the governing board
    - Performance in appropriate HEDIS measures which meet or exceeds fee for service for a matched risk adjusted population or which shows a reduction in disparities year over year.
    - Good performance on SNP Structure and Process Measures
    - Consumer support and satisfaction measured by appropriate surveys and focus groups

2. *What specific plan design flexibilities would promote improved care delivery and streamlined administration*?

    ACAP supports developing an integrated program model for duals that is more similar to the PACE program's unique recognition as a Medicare/Medicaid coordinated approach rather than the current placement of Dual SNPs within the MA program.
    - Single ID card
    - Combined enrollment process

- A single set of member materials including clear explanations of how the full array of Medicare and Medicaid benefits work in concert to meet the person's care needs
- Unified appeals and grievance processes
- Unified monitoring of call centers, marketing etc which is tailored to the integrated product.
- Payment aligned across the Medicare and Medicaid programs that does not require bidding within the current Medicare Advantage system
- A single encounter- data protocol and reporting
- Recognition that states may want the FIDESNP status for plans which serve a sub-set of duals and/or some of the benefits especially in the long term care supports and services.

3. *What incentives (such as seamless enrollment transitions) would best promote plan participation in this initiative?*

- A payment system to integrated plans that is not based on the current bid structure.
- Exemption from some of the MA payment reductions that are provided to PACE programs
- Seamless enrollment transitions from current SNP plans into the new models.
    - *Note: Currently, SNPs are organized at the plan benefit package level rather than the contract level. This means that dual eligible SNPs co-exist within the same contract with other types of MA plans. All SNPs,not just FIDESNSPs should be reorganized at the contract level by 2013.*
- Seamless conversion from state MLTC plans to new or existing models which integrate care with Medicare. For example, NY State has various initiatives that could be aligned.
- Alignment across FFS shared savings proposals and payments to plans to ensure that providers are paid appropriately for improving care within a plan structure and not be incented to return to a less coordinated FFS approach**.**
- Risk adjusted performance measurement
- Enrollment approaches which are inclusive of all eligible person with clear "opt-out" procedures
- Performance measures which are tailored to the duals population and the sub groups within it.

4. *What additional care coordination or beneficiary protection requirements would be appropriate for participating SNPs?*

The best beneficiary protection is to assure consistent eligibility in the Medicaid program.

- As an incentive for individuals to participate in integrated arrangements that will provide higher quality and lower costs over time, offer continuous eligibility for 12 months to participants in integrated programs.
- Provide seamless enrollment within the same plan organization for persons transitioning from Medicaid only status to dual status. Currently, employees who

become eligible for Medicare are offered a seamless transition process within their health plans that is not consistently used for Medicaid beneficiaries who become eligible for Medicare as duals. The number of people who are enrolled in a Medicaid plan whose coverage will be disrupted when they become duals will grow exponentially over the next few years. More states are enrolling the SSI population so that the person with disabilities is likely to be enrolled in a plan at the time the two year waiting period for Medicare is met. By 2014, when categorical eligibility for Medicaid ends and all persons below the 133/138% federal poverty level will be in the Medicaid program, the number of 64 year olds who become "duals" immediately upon reaching age 65 will be much greater than now and given current trends are likely to be enrolled in a Medicaid plan at the time of transition to Medicare.

- Create real- time data exchanges for eligibility information across the SSA,CMS, IRS, VA and state systems
- Require states to use ex- parte information and prohibit passive disenrollment for failure to return eligibility forms at the time of renewal.
- Provide better information to duals about the full range of options available to them for drug coverage. Currently, they receive PDP information in isolation from other Medicare options especially those offered by their Medicaid plan.

Other beneficiary protection should include the following:

- Clear "opt-out" procedures for persons in inclusive programs
- Strong, cross-state, formal evaluations of initiatives and models

<u>All Dual Eligible SNPs Required to Contract with State Medicaid Agency</u>
Our knowledge of state budget and procurement rules make a February date simply unrealistic as the due date for the state contracts. A contract clause from the previous year which assumes following year contracting or a letter of intent to contract may be the best solution to trying to align federal and state dates. A July or August due date for these document would work. Alternately, if fully integrated plans were exempt from the bid process as we suggest above, aligned Medicare and Medicaid dates could work outside of the Medicare Advantage calendar.

<u>Clarification of Parent Organization Information for MA Organizations and PDP Sponsors</u>
ACAP supports this level of transparency.

<u>Improvements to Plan Ratings</u>
This section has some very good introductory language about relative burden, tested measures and appropriate benchmarks yet the proposals do not always match this good framework. We would like to see a few good, risk adjusted measures that compare plan enrollees with a like set of FFS enrollees, all cause readmissions and preventable admissions might be a good start. We would like to see the plan oversight be more strategically aligned with the separation of monitoring and quality improvement envisioned for the fee for service work through the QIOs.

We are also very concerned about throwing a bunch of disparate measures into a pool of measures, weighting randomly and assigning stars. We call your attention to a recent Malcolm

Gladwell article in the New Yorker on the folly and false precision in the amalgamation of measures such as those used for college rankings and the comparisons of cars. Has there been any study of the weighting used in CMS star rankings? Are the relative weights and break points supported by any research? And, if they change year to year what will this mean to efforts to measure and report on quality improvement?

We do support display of some of the SNP Measures. The Care of Older Adults measure may not be the best place to start as most of the enrollees in our plans are under age 65. We suggest that CMS review all of the SNP reporting requirements and consider which ones should remain and then refine both the measures and develop a public reporting process. Perhaps, CMS could contract with NCQA to develop a SNP Quality Compass to make the data currently collected available to the public.

CMS also asked for specific feedback on plans that were non compliant in non-quality areas. Plans with severe compliance concern should be engaged in a corrective action plan, but the quality rankings should NOT be adjusted and should be displayed as they are with an asterisk or other notation about the other compliance issues.

We are concerned about adding new measures when some of the current measures need more refinement. For example, the CAHPS survey is only available in English and Spanish which has the effect of excluding up to 40% of the enrollees in some safety net plans on the basis of language alone. Other SNP members are excluded due to frailty and to profound physical or mental disabilities. The measures also assume a curative or medical model.

More effort is needed to address performance measurement appropriate to the types of conditions that members may have. Some measures may be contraindicated for persons with multiple chronic conditions or advanced stages of illness and others may be unnecessarily risky if, for example, a person with profound developmental disabilities has to be sedated for a routine mammogram. The AHRQ report on quality describes that “for patients with long-term health conditions, relieving symptoms, enhancing quality of life, and preventing complications are important goals. Providing emotional and spiritual support to patients and their families during serious and advanced illness and honoring patient values and preferences for care is critical.”

<u>Contracting Organizations with Ratings of Less Than Three Stars in Three Consecutive Years</u>

We agree that CMS should not continue to contract with organizations whose performance is consistently out of compliance with Medicare requirements. However, earning less than three stars may not be an indication of a “compliance problem”; it may be a factor of no risk adjustment in the measures and of underlying disparities as outlined in the recent AHRQ reports. We urge, especially for safety net health plans, further investigation into those plans to detect any special factor which make the ranking system imprecise in measuring value to the enrollees. Otherwise, you run the risk of disrupting the care for beneficiaries in systems that may actually be the only source of care willing and able to serve them. An alternative may be to provide enhanced support in quality improvement from an appropriate Quality Improvement Organization as part of a corrective action plan.

Thank you for the opportunity to submit these comments. We and our plans would be happy to discuss further. Please contact Mary Kennedy, Vice President of Medicare at 202-701-4749 if you wish to discuss.

Sincerely,

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Chief Executive Officer, ACAP

Cc: Melanie Bella
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