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Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

January 11, 2011

To: Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8013
Attn: CMS 4144-P
Baltimore, MD 21244-8013

Re: Medicare Program; Proposed Changes to The Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Proposed Changes; Proposed Rule CMS–4144–P.

Submitted electronically on January 11, 2011.

I write on behalf of the Association for Community Affiliated Plans (ACAP), an association of 53 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. Approximately 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. We appreciate the opportunity to comment on these regulations to help ensure that non-profit community based plans may continue to serve their dually eligible members.

ACAP supported passage of the Affordable Care Act and recognizes that much of this proposed rule focuses on implementation of that law. Our comments are limited to those areas that are most germane to the operation of our non-profit plans.

417.101 / 422.1000 Cost sharing – ACAP supports the proposed regulation and CMS' use of discretion around home health benefits.

422.2 Definition of "fully integrated dual eligible special needs plan" (FIDESNP) - ACAP supports CMS' proposed definition especially the language "*includes coverage of specified primary, acute and long term care benefits and services, consistent with state policy*." Use of the word "specified" in this definition recognizes that states may vary in the degree to which Medicaid services are included in the contract. We suggest that the word "specified "also be added prior to "dual eligibles" as states may choose to contract for certain sub- groups of duals such as those who are elderly or those who meet an institutional level of care. We trust this

[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).

definition, once adopted, will allow further development of policy to align care for duals in the future.

422.4 Type of MA plans - NCQA approval for SNPs - We think the language here could be further clarified to link this approval process more explicitly to the work NCQA already performs around SNPs. The review schedules used by NCQA should be decreased for better performing plans to allow for more technical assistance and oversight to new and developing plans. NCQA has been an active and consistent partner in working with our SNPs and we would like to see and comment on a plan that links this new approval process with the existing oversight and quality improvement work they perform on behalf of CMS.

422.11 and 423.128 Customized out of pocket statement - We agree that duals should not receive such a statement because of the Medicaid obligation for their cost sharing.

422.62 Election of coverage - We read this language as preserving the election periods currently available to duals. We urge CMS to develop additional processes to assure that duals can elect to seamlessly join and remain with the same plan sponsor for Medicaid and Medicare in both FIDESNP models and in Medicaid models which cover only acute services.

422.106 Coordination of benefits with employer or union group health plans and Medicaid ACAP strongly urges CMS to develop similar waiver authority for FIDESNPs and for coordination with Medicaid acute benefits as it has outlined here for employer sponsored plans. "CMS may waive or modify any requirement in this part or Part D that hinders the design of, the offering of, or the enrollment in….." We were surprised to see this broad waiver authority for employer sponsored plans and ask CMS to comment on why such language is not used to ease coordination with Medicaid programs on behalf of duals.

422.107 Contract with State Medicaid Agency – ACAP notes that this section conforms to language in the Affordable Care Act. We urge CMS to make it clear in its operations that SNPs continuing in the same area must have a contract for plan year 2013. Because all SNPs have to complete the SNP portion of the "application " annually, it has appeared as if CMS was imposing this requirement during 2012 on existing plans operating in the same area. We also ask that CMS understand that final state contracts may not be available until October of each year. And, we urge all parts of CMS to work together with states on the contracting process and support states who wish to have ongoing or multi- year contracts with payment and other amendments as needed.

422.152 Quality improvement program - This language seems to de- link the QIPs and CCIPs from the compliance deeming for accredited plans. The language in the pre-amble that this is less burdensome does not make sense. The whole purpose of deeming is to reduce duplication. Is CMS delinking these projects for another reason such as the ability to implement nationwide QI programs in specific areas? And, how does this language align with the NCQA "approval" for SNPs?

422.262 (ii) No variation in cost sharing allowed - This language seems overly restrictive in an environment where tiered networks may be useful to promote quality or where co-pays could be reduced if the beneficiary received appropriate care at recommended intervals.

422.266 Beneficiary rebates – ACAP urges CMS to analyze the effect on duals, especially very complex duals, which will occur when rebates are reduced to plans that are challenged to earn 4 or 5 stars under the quality payment system. Since the quality metrics are not scaled in any way by the risk of the population, beneficiaries in plans with high concentrations of complex needs with see a downward ratcheting of their benefits. This is especially troubling as states are reducing "optional" Medicaid benefits to duals.

Subpart G - Payment to Plans

422.308 (4) Frailty adjustment – The ACA was passed without benefit of a reconciliation process and the frailty language is one area where such a process would have helped. ACAP urges CMS to use reasonable flexibility and apply the frailty factor on a person, not plan basis or states will be incented to carve up their Medicaid populations into those who are NH or LTC certifiable and those who are not. While there are excellent reasons and programs that focus solely on the LTC population, there are also compelling reasons to have all duals in one plan and to seamlessly manage the transitions to a higher acuity level. We strongly believe plans should be paid for the risk of the population actually enrolled and not on risk avoidance.

And, even if CMS bases the adjustment on plan acuity, then the acuity level similar to PACE should be payable on the range within PACE plans and not on the "average" of PACE plans.

We also have a concern about the process outlined and the requirement that the plan pay for the survey. As the FIDESNP category is used more, we also urge CMS to be flexible in coordinating with and using ADL assessments from the states.

422.308 (6) Risk adjustment – Again ACAP urges flexibility in expanding on the intent of the ACA in the area of risk adjustment for persons with chronic illness. This process should apply to all SNPs. Persons under age 65 who become eligible for Medicare do so because of a disability and the duals under age 65 are even more likely to have a long history of chronic as well as disabling conditions. They are also more likely to have co-occurring mental health needs. It is critical that payment to the MA plan recognize the needs of the under 65 person with a disability who transitions from a Medicaid - only category to dual status. Prior claims data is available through the Medicaid program and should be used to set payment upon entry to a SNP. ACAP has numerous plans where membership of the under 65 dual exceeds elderly duals and the current risk adjustment system unfairly assumes these "new to Medicare" beneficiaries are healthier than their history shows.

We understand that the annual rate notice will show how CMS has implemented the refinements on risk adjustment required by the ACA.

Quality Bonus Payments

ACAP is supportive of the three year demonstration for payment years 2012 to 2014. The recognition of improvement by 3 and 3.5 star plans is a good first step. The underlying framework for quality measurement is simply not ready to be used as a payment methodology. We trust that CMS will use the demonstration period for rapid learning and implementation of methods to appropriately measure and reward quality improvement. The demonstration, as structured, does not go far enough in recognizing the challenges in caring for dual eligibles. The opportunities for care improvement are significant if incentives are correctly focused on the various sub- groups of the duals. ACAP believes it is especially critical that CMS use this demonstration period to determine how to recognize the disparities in health status of the dual eligibles and find ways to both appropriately measure the quality of care and to pay the plans that serve this population. Preliminary analysis on the Stars system indicates that plans which avoid serving high need individuals will do best as there is no risk adjustment in the process.

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 refine how SNPs should be evaluated.

Within the dual eligible category, we do not think there has been enough analysis around frailty, mental health, developmental disabilities, and the needs of persons with significant physical disabilities. In addition, the quality measurement field is also not mature around co-morbid conditions. Because ACAP member plans have Medicaid as a core business, the SNP plans have a very disparate enrollment of duals under age 65 when compared to commercial MA plans. We urge CMS to look further at plan composition and find ways to sustain plans which focus on the person with high needs. The work around risk adjustment needs to renew its focus so that quality improvement to reduce disparities is as much a priority as assuring relatively appropriate overall payment in plans with a million or more members.

A key component of the quality measurement system is the consumer feedback acquired through CAHPS. CAHPS was not developed for payment purposes and the downward adjustment made to the responses of Dual Eligibles continues to be a concern. In addition**,** the availability of CAHPS in only Spanish and English excludes the experience of significant numbers of enrollees in safety-net duals plans.

We also urge CMS to align its strategies across FFS shared savings proposals and its 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**.**

422.504 Uniform complaint system - We support the requirement to have a uniform and transparent complaint system. There are various ways our plans read the language in the draft. It is clear that the CMS complaint form must be available to all members. Is the intention that all complaints from whatever source be sent to CMS via this form? If so, we hope CMS anticipates the ability to upload data directly from a plan's current internal tracking system. Separate,

manual entry would be extremely burdensome. We also hope CMS tests the capacity of its system to support the volume of interactions before implementation.

Subpart V – Marketing Requirements

422.2264 and 423.2264 Guidelines for CMS review - In general, the foreign language requirements are less restrictive than those in Medicaid programs. One area where we believe CMS could improve materials is by imposing an English language reading level test. Medicaid programs tend to require materials to be at the 5th to 7th grade reading level.

422.34 Enrollment of LIS - As we comment each year, we urge CMS to offer better enrollment 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. And, the seamless enrollment offered to employees transitioning into Medicare is not consistently used for Medicaid beneficiaries who become duals.

Appropriate dispensing of drugs in long term care facilities - ACAP supports the ACA requirement to dispense brand-name drugs in 7 day increments. We re also pleased to see the option for plans to apply this method to generic drugs. We are concerned that the uniform dispensing techniques are at the LTC facilities' discretion. This would lead to more concentration in the long term care pharmacy business and potentially increase costs. Changing to single dispensing method would also potentially disrupt PDP/MAPD coverage for the many beneficiaries with short term and rehab stays in a LTC.

423.772 HCBS cost sharing – ACAP urges CMS to require more frequent updating of HCBS and other eligibility data. A person may enter HCBS at any time of the month.

423.2274 Training for agents and brokers - While we recognize and support the need for standardized training, we believe that a low- cost option should be made available through the public or non- profit sector and urge CMS to limit the cost of such training in their RFP process. On-line training, testing and certification should be available.

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, and Medicare Programs at 202-701-4749 if you wish to discuss.

Sincerely,

Margaret A. Murray
Chief Executive Officer