ACAP
Association for Community Affiliated Plans

1015 15th Street, N.W., Suite 950 | Washington, DC 20005
Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net
Howard Kahn, Chairman | Margaret A. Murray, Chief Executive Officer

March 1, 2013

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: AdvanceNotice2014@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) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter.

ACAP is an association of 58 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. An additional group of plans will be offering Medicare-Medicaid Plans in 2014 and therefore, are interested in the risk adjustment pieces. Our comments follow in order of the Advance Notice and the Call Letter. As a general comment, we request that future Call letters give more consideration to all policies and their effect on D-SNPs and the new Medicare-Medicaid plans in the same manner that there is different guidance for Cost Plans and for PACE organizations.

ADVANCE NOTICE

MA Growth Percentage (p.5)
ACAP appreciates CMS' acknowledgement that the negative growth percentage is quite a challenge and that you "*solicit comment on suggestions to address these challenges within the parameters of current law.*" We remind you that plans serving full benefit dual eligibles through D-SNPs are especially challenged as there are additional administrative requirements on the plans and there is **no realistic way to increase premiums to this low income population to offset the loss of federal funding.** The over 1.3 million beneficiaries in D-SNPs are at risk of losing access to a coordinated care plan. Furthermore, the non-profit community based plans in ACAP do not have large MA plans or commercial business to balance the losses on their D-SNP business in a particularly poor year of reimbursement. We understand that if the scheduled physician payments cuts are not allowed to go into effect as has been Congressional practice, the MA/SNP would be approximately 5% higher. We ask that CMS make the assumption that physician cuts will not take place and go forward into the bid process with this assumption.

We also ask that CMS take notice of other emerging issues and recognize current costs in the rates for 2014. Plans participating as Integrated Care Organizations (Medicare-Medicaid Plans) in the Massachusetts duals demonstration project note that the preliminary ICO Demo rates did not account for the effect of the Nantucket Hospital being considered as a rural hospital. The failure to account for these changes represents approximately $75-$100M for ICO in total. We think it should be possible to adjust the base spending only for the ICO plans to reflect the new FFS costs. Such a change would assure that the Massachusetts demonstration is a viable test of improved care to persons enrolled in both Medicare and Medicaid in that state.

Effects of Sequestration on MA Rates

Per your call with plans, we understand that CMS is not ready to address how Medicare cuts under the sequestration will affect 2014 rates, but another 2% cut would be devastating to the ACAP SNP plans.

Section A. MA Benchmark, Quality Bonus Payments and Rebate (p.9)
We support the current Star quality bonus payment system which provides some payment recognition of plans at three stars and above. As you know from our comments over the years, we feel that the Stars system would be greatly improved if it fairly assessed quality in D-SNPS against the quality of a matched co-hort of fee for service duals. It does not seem fair to the plans who serve a specialized population to be compared with plans with a much lower risk profile in a risk adjustment system which is also not as accurate as it could be for the highest need individuals. D-SNPS have a disproportionate numbers of the very elderly and of the lowest income beneficiaries with disabilities. Plans with lower Star ratings have less money in rebate to provide benefits and reduce premiums, therefore it's very important they have an accurate quality assessment or the very vulnerable populations they are designed to serve are further disadvantaged by having a lower percentage of premium available to offset premiums or increase benefits.

Section G. Recalibration and Clinical Update of the CMS-HCC Risk Adjustment Model (p.16)
ACAP is very pleased to see an update and recalibration of the HCC model. We support updating data years and adding more advanced disease stages.

ACAP supports the new enrollee factors and suggests that further work could be done to improve the accuracy of payment for those new to Medicare especially when there is Medicaid claim experience for new duals.

ACAP believes that dementia diagnoses should be included. In states which are enrolling a high proportion of dual eligibles, people with dementia will be a substantial portion of D-SNP or the new Medicare-Medicaid plans. This is a data or coding problem that needs to be solved.

ACAP is concerned that one of the changes, which combines diabetes with renal and neurological manifestations with other chronic diabetes measures, is not appropriate as the costs are distinct and this would negatively affect payment for plans serving very high-need individuals.

Section H. Medicare Advantage (MA) Enrollee Risk Assessments (p.22)
ACAP does not support the proposal to require two additional claims to enforce the HCC risk score. This seems to be supportive of a FFS model, incentivizing potentially wasteful and unnecessary services, and does not give credit to care management or the Models of Care requirements in D-SNPS. We do support current requirements for use of health professionals.

Section I. Adjustment for MA Coding Pattern Differences (p.23)
ACAP believes there is truly a different beneficiary mix than might have happened with random enrollment into MA when a state has an active duals integration model. In fact, it would be impossible for a D-SNP or a Medicare-Medicaid Integration plan to comply with the Model of Care requirements and NOT have a coding intensity that is substantially greater than fee-for-service. This is another area of agency discretion that could modify the proposed reduction. Could there be some difference in calculation or application of the normalization factor for D-SNP (now) and Medicare-Medicaid plans (in future years)?

Section K. Frailty Adjustment (p.25)
ACAP continues to support functional status as a necessary component of good payment policy.

CALL LETTER

Star Ratings Changes (p.89)
We strongly recommend fair comparison of plans. Comparing D-SNPs to other D-SNPs and to a matched cohort of FFS beneficiaries should be done. Other risk adjusted quality comparisons would also be welcome.

Plan/Sponsor Continuity of Operations (COOP) (p.105)
ACAP is supportive of standards and looks forward to seeing them. ACAP acknowledges that to be operationally capable within 12 hours may be difficult depending on how serious the damage.

Year 7 Agent/Broker Compensation Guidance (p.106)
ACAP supports efforts to minimize incentives to brokers for plan changes.

Part D Payment Reconciliation
We are in agreement with CMS' process for establishing risk percentages for Part D risk sharing but disagree with combining Part D plans with MA (non D-SNP) and D-SNP plans, since MA and D-SNP plans are inherently at a disadvantage compared to Part D plans. Instead, we feel that Part D and MA and D-SNP plans should be evaluated separately when establishing risk percentages for Part D risk sharing.

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