



March 4, 2011

Jonathan Blum
Deputy Administrator and Director
Center for Medicare
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Washington, DC 20201

Submitted via email to: AdvanceNotice2012@cms.hhs.gov

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2012 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2012 Call Letter

Dear Director Blum:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to comment on the “45-Day Advance Notice” and 2012 Call Letter. ACHP is a national leadership organization representing community-based and regional health plans and provider organizations that provide health care and coverage for approximately 18 million Americans. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems. Most of our member plans provide health care coverage for substantial numbers of Medicare Advantage enrollees and have done so over many years as part of their long-standing commitment to their communities. These delivery-aligned plans are characterized by close partnerships with providers and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality. According to NCQA’s 2010-11 quality rankings, nine of the top ten Medicare plans in the nation are ACHP member plans. Collectively, these plans provide care and coverage for all enrollees in 5-star plans and 75 percent of enrollees in 4.5 star plans.

We appreciate that CMS has moved forward to implement important provisions of the Affordable Care Act (ACA) and we especially welcome the expressed commitment to improve the quality of care available to Medicare Advantage beneficiaries through implementation of the quality bonus provisions and the new quality bonus demonstration project. We also recognize and support CMS’ commitment to strengthening beneficiary protections and appreciate that CMS has been more explicit in its requirements and expectations with this Call Letter, as we and others had requested.

ACHP has reviewed the Advance Notice and Call Letter with our member plans, who have identified several significant concerns as well as guidance that we believe requires clarification. We provide recommendations on many issues below, but would highlight several major issues:

- **Quality Bonus Payments (QBP):** ACHP supports a gradient of incentives to promote high quality performance; achievement of higher quality ratings should be rewarded with greater incentive payments, as contemplated in the ACA. We would support CMS extending

MAKING HEALTH CARE BETTER

application of the QBP to the full blended benchmark, currently available only to 5-Star plans in the demonstration, as CMS has proposed. Because the transition to new blended benchmarks is as long as six years under ACA provisions, CMS may want to consider extending the demonstration to the same period of time to accommodate the counties subject to the six-year transition and avoid a large decrease in payments during the transition.

- Improving Performance Measures: ACHP supports CMS' plans to expand and improve upon the measures used to rate health plans. We particularly encourage CMS to provide greater weight to clinical measures and less weight to process and compliance measures in the star rating system. We provide a number of specific comments, and would note here our support for the development of measures of care coordination, care transitions, and patient activation. We urge CMS to consult with stakeholders and seek review by clinical experts, and to allow for a period of testing, before use of new measures in the quality rating system.
- Beneficiary Protections - Total Beneficiary Cost (TBC) and Out-of-Pocket Costs: ACHP supports the second of the two TBC alternatives presented – prospective determination of the TBC threshold. This would better facilitate the ability of MAOs to develop their plan cost-sharing parameters and prepare bids for submission to CMS. We urge CMS to be fully transparent in the data and assumptions used to determine the annual TBC and OOPC amounts and to make such information available well in advance of when MAOs need to submit their bids.

More specific comments follow:

ADVANCE NOTICE

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

CMS estimates the National Per Capita MA Growth Percentage for 2012 (for the Aged and Disabled populations) at 0.7% and also notes that the estimate could change when the final rates are announced on April 4, 2011. We request that CMS clarify how it arrived at this estimate, which appears lower than what would otherwise have been expected. ACHP encourages CMS to include the key assumptions underlying the estimate, as well as greater documentation of data analyzed, in Advance Notices for futures years to assist organizations in understanding the basis for, and the calculation of, the growth percentage for a year.

CMS also advises in the Advance Notice that a solution to the Medicare physician payment methodology, either a temporary fix for 2012 or permanent, would improve payment rates for Medicare Advantage plans and would affect MA rates for 2012. While ACHP understands that the agency must await Congressional action on the matter, ACHP seeks clarification from CMS on the deadline by which the agency would be able to make a decision that would affect CY 2012 payment rates.

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

Section A. MA Benchmark, Quality Bonus Payments and Rebate

Quality Bonus Payment Demonstration/Applicable Percentage Quality Increase

CMS previously announced a three-year demonstration project to supplement the ACA provisions for quality bonus payments (QBPs) to MA plans. That demonstration modifies the ACA provisions, which provided bonuses only for 4- and 5-star plans, and extends bonus provisions to plans at or above 3 stars. It also provides additional incentives for 5-star plans, most notably application of the QBP to the entire blended benchmark and not just the pre-ACA applicable amount, as well as a special enrollment period for 5-star plans.

ACHP appreciates the opportunity to comment on further potential modifications to the demonstration proposal. Specifically, CMS is now considering applying the QBP percentages to the blended benchmark for all plans with 3 or more stars. ACHP has strongly supported the idea of a gradient of incentives for quality performance. The right incentives are created when different QBPs are provided for the different ratings which, especially in the context of the demonstration, will allow for an analysis of whether or not the program is achieving its goals. In addition, quality bonus payments can help provide the financing for investments required to achieve higher levels of performance.

In ACHP's earlier comments on the demonstration, we supported the special provisions in the demonstration for 5-star plans, including the application of the QBP to the blended benchmark, and suggested that CMS consider applying those provisions to 4-star plans as well, since Congress had recognized both 4- and 5-star plans in the ACA's bonus provisions. Extending that treatment to 4-star plans would include plans serving about 23 percent of enrollees according to MedPAC's recent comment letter to CMS. Further extending the QBP to the blended benchmark for all 3- and 3.5 star plans would include plans serving 80 percent of enrollees. ACHP is supportive of the revised demonstration project as proposed by CMS in the Advance Notice. We suggest, however, that in the future a greater distinction between bonus provisions that apply to high-performing plans and those applicable to others would strengthen the incentive for plans to move up to the highest levels of quality ratings.

CMS notes that, if it extends the QBP under the demonstration to the blended rate for plans other than 5-star plans, it is considering whether the benchmarks to which the QBP is applied need to be capped under the revised design. We would propose that the approach mirror that currently provided under the demonstration for 5-star plans, which is that CMS would not cap the blended benchmark at the level of the pre-ACA benchmark.

Further, CMS asked for comments on approaches for phasing from the three-year demonstration to the statutory ACA provisions. ACHP notes that the schedule for phasing in the blended benchmarks under the ACA is as much as six years in some counties, and suggests that the demonstration extend for that same six-year period. In particular, this would avoid the problem of plans in longer-transition counties "falling off a cliff" when the demonstration project ends and seeing a large decline in their payments.

Section I. Employer Group Waiver Plan (EGWP) Bidding

The Advance Notice reviews a March, 2009 MedPAC report, validated by CMS data, that suggests that employer group waiver MA plans offered exclusively to employer/union group sponsors have lower projected risk scores but higher bids than other MA plans. CMS invites comments that may explain this discrepancy.

The experience of ACHP member plans is that the most likely explanation is an imprecise methodology for adjusting for the risk and use differences between such waiver plans and other MA plans. It is possible that people at higher risk tend to stay in the EGWP plans and use more benefits. We suggest that CMS make its methodology public for the computations presented in Section I to allow a better understanding of the differences, including, for example, any differences among such waiver plans. We would be pleased to arrange for actuarial experts from our member plans to review with the agency the rationale for these differences before any policy changes are contemplated.

Section N. Normalization Factors

The notice provides preliminary normalization factors for each risk adjustment model but does not indicate the underlying data and risk scores for organizations to better understand resulting trend and other factors. For example, the Advance Notice merely indicates that for the CMS-HCC aged-disabled risk adjustment model, the preliminary normalization factor is 1.079, which is higher than in years past. In estimating the average predicted expenditure increase after the model calibration year, CMS takes into account coding and population changes in applying a normalization factor to adjust beneficiaries' risk scores to attain an average risk score of 1.0 in subsequent years. ACHP is unclear how CMS arrived at the preliminary normalization factor of 1.079, especially in light of the demographic shift due to the great numbers of new enrollees of the baby boom generation who increasingly will add a healthier cohort to Medicare. ACHP member plans are concerned that CMS underestimated the impact of this significant demographic trend of relatively younger beneficiaries and seeks guidance from the agency as to the degree to which the calculation of the normalization factor took into account the large numbers of newly eligible Medicare beneficiaries now enrolling in the program. ACHP also recommends that the agency release underlying data and risk scores to avoid similar confusion in future Advance notices.

Attachment III. Changes in the Payment Methodology for Medicare Part D for CY 2012

Section E. Payment Reconciliation

The Advance Notice indicates that CMS will apply no changes to the risk percentages applicable for 2011 for contract year 2012. CMS evaluated risk-sharing amounts provided for the 4-year period beginning with 2006 and determined that risk-sharing amounts continue to vary significantly for Part D sponsors and that the aggregate risk-sharing amount paid varies from year to year. ACHP encourages CMS to review its data and to use its authority to make appropriate adjustments to the risk percentages to reduce the incidence of recoupment of payments from plan sponsors under the risk corridors.

2012 CALL LETTER (Attachment VI)

Proposed Initiative to Promote Enrollment in Fully Integrated SNPs

ACHP looks forward to learning more about CMS' consideration of an initiative to promote enrollment of dual eligible Medicare and Medicaid beneficiaries in fully integrated, high quality special needs plans (SNPs). We support CMS' intent to focus on plans that are of demonstrably high quality and that offer a truly integrated product. CMS asks for comments on potential plan design flexibilities. One option to consider is to further extend the provision in Sec. 3205(d) of the ACA, which extends through 2012 the statutory waiver on requirements that plans for special needs individuals have a contract with a state. While SNPs can and do make every effort to enter into such contracts, that has not been possible in some states. If a fully integrated SNP meets the high quality standards and other regulatory requirements envisioned by CMS, extending the statutory waiver on plans without contracts would be an effective means of promoting enrollment and should not reduce the integration of services available to these beneficiaries.

Improvements to Plan Ratings

CMS proposes a set of enhancements for the 2012 and 2013 Plan Ratings, identifying specific measures that are under consideration to be added in 2012 and 2013. ACHP strongly supports and commends CMS for the effort to expand and improve upon the measures used to rate health plans. We believe that CMS has laid out a reasonable set of principles to guide its consideration of new measures; these principles are consistent with the "Triple Aim" approach to improving the delivery of care that guides our member plans. We believe that measures should be aligned across Medicare and Medicaid, to the extent practical, given their different populations. And we also support aligning the measures that are developed with those endorsed by multi-stakeholder groups.

ACHP appreciates the caution that CMS has expressed in adopting measures to make sure that all measures included for 2012 are reliable and valid. For all future measures under consideration, we urge CMS to consult closely with clinical experts and all stakeholders and build in a year of testing before measures are used in the rating system. We also encourage CMS to continue to evaluate existing measures for validity and identify potentially problematic measures that show inconsistency of plan performance from year to year.

We have a number of comments on the measures under consideration for 2012 and 2013:

- We support inclusion of the new HEDIS® all-cause readmission measure as soon as practical.
- We have some concern about the use of hospital quality measures, which are collected for fee-for-service beneficiaries and not for an MA population. Because MA plans add elements of care coordination and provider support for MA enrollees in the hospital, scores collected on patients in MA plans may be different from scores for fee-for-service patients. These measures should not be used until data is collected for MA enrollees. Also, these measures can be subject to substantial variation, especially for small hospitals. And in many regions there is only one hospital available, so the measure under consideration for 2013, "use of highly rated hospitals," is problematic.
- We support the development of measures of care coordination, care transitions, and patient activation. In addition to survey measures, claims-based measures may be appropriate – for

example, number of days before a patient visits a physician after discharge is an indicator of care transitions. Emergency department visits for Ambulatory Care-Sensitive Conditions can be an indicator of whether good primary care is provided and coordination of services managed by the health plan in the outpatient setting across providers. Measures such as these will have to be carefully considered and vetted broadly.

- While ACHP member plans generally have excellent retention rates, voluntary disenrollment occurs for a number of reasons which may have nothing to do with the quality of the plan or the patient's experience. Accordingly, we suggest reconsideration of this measure for the 2012 ratings.
- In the list of possible measures for 2013, we suggest that evaluation of a contract's Chronic Care Improvement Program and Quality Improvement Project" is not as meaningful as the various clinical quality and outcomes measures that more directly reflect the effectiveness of a plan's quality improvement activities.

CMS notes that it is considering providing greater weight to clinical measures and less weight to process measures in further revisions of the star rating system. ACHP urges CMS to move in that direction. We believe that the best outcome of the quality bonus system that Congress enacted should be measurable gains in clinical quality, and that the star rating system should be re-oriented to reflect that goal. While it is very important for beneficiaries to have a positive customer service experience and for plans to meet CMS' administrative expectations, improved clinical outcomes, use of best available medical evidence, and receiving the right treatment at the right time from the appropriate provider is of direct consequence to their health. Measures of such clinical outcomes should therefore play a more important role in a plan's star rating score than such process measures as call center wait times.

CMS advises in the Call Letter that, as it modifies the plan ratings, it is incorporating certain principles, one of which is to score plans "on their overall achievement relative to national or other appropriate benchmarks. In addition, scoring methodologies should consider improvement as an independent goal." We believe that CMS can best encourage organizations to strive for the highest quality rankings with a graduated system of bonus payments that provides greater rewards for higher levels of achievement. This is the approach of both the ACA provisions and the CMS demonstration project. By extending the opportunity for plans to receive QBPs through the entire spectrum of star ratings, with higher rewards for higher ratings, CMS essentially is providing rewards for improvement. We are uncertain of CMS' intent, but suggest that separate payments for improvement will further blur the distinction between high-performing plans and others and that CMS should not add this element to its payment methodology.

Special Election Period for Enrollment in 5-Star MA Plans

CMS provides additional guidance related to the establishment of a Special Election Period (SEP) that will allow beneficiaries who are eligible for MA plans to enroll in 5-star MA plans, a policy announced in a November 19, 2010 HPMS memorandum. One criterion is that individuals "will be eligible for this SEP only if they are either enrolled in MA plans with a star rating of 4.5 or less, or enrolled in Original Medicare and meet the MA eligibility requirements. Individuals already enrolled in 5-star MA plans are not eligible for the SEP." We request clarification that eligible individuals can enroll in 5-star MA-PD plans as well as MA-only plans.

Duplicative Plans and Plans with Low Enrollment

CMS indicates that during April or May 2011, it will send each MAO a list of low enrollment plans that have been in existence for three or more years but, as of April 2011, have fewer than 500 enrollees for non-SNP plans and 100 enrollees for SNP plans. (Exceptions will apply to plans meeting certain criteria.) MAOs with low enrollment plans will have to provide justifications for contract renewals. CMS indicates that it will consider reasonable factors when evaluating whether specific plans should be renewed even if they are below the 500-member enrollment threshold.

ACHP agrees that low-enrollment plans generally should be discouraged from continued participation in the MA program and appreciates that CMS intends to consider factors that may merit exceptions. In that light, we urge CMS to consider the special circumstances for 800 series plans in determining whether a contract should not be renewed on the basis of low enrollment. Because it is a CMS requirement for 800 series plans that they be offered to individuals as a condition for being offered to employers, these plans may not be as well positioned to attract enrollment as MA plans that are marketed exclusively to beneficiaries.

Duplicative Plan Offerings

CMS indicates that for CY 2012, it will use plan-specific out-of-pocket cost (OOPC) estimates to identify meaningful differences among similar plan types. MAOs will have access to CY 2011 OOPC estimates for each of their current plans and an OOPC model available in SAS from the CMS website.

ACHP recognizes the ongoing efforts by CMS to identify meaningful differences among similar plan types to assist beneficiaries in making plan choices. We appreciate the additional specificity of these requirements with this Call Letter and welcome steps by CMS to help plans calculate OOPC differences in a manner consistent with those determined by CMS. However, our member plans urge CMS to provide for greater transparency with respect to the inputs for the model that is used to make the calculations. Also, plan experience indicates that the tool may not account well for certain benefits. Thus, specific information is needed on the inputs needed to run the SAS tool. We urge CMS to release that tool at the earliest possible date and to provide an explanation of logic behind these calculations in addition to the programming code. Our member plans would also appreciate an opportunity to seek technical assistance from CMS on the SAS tool as they prepare their CY 2012 bids, particularly in light of the fact that CMS may not permit revised submissions if a plan's initial bid does not comply with the meaningful difference requirements.

The OOPC calculation does not take into account other benefit design features that are valuable to beneficiaries and should be considered when determining whether two plan offerings are meaningfully different. Such factors include mandatory supplemental benefits not included in the OOPC calculation such as hearing and vision services,¹ premiums, and Part D benefit features such as the initial coverage limit and breadth of formulary coverage.

In addition, CMS proposes that there be a total OOPC difference of at least \$22 per member per month between each plan to be considered meaningfully different. This is a 10 percent increase

¹ <http://www.medicare.gov/MPPF/Include/DataSection/OOPC/OOPCCalculations.asp?language=English>.

from the \$20 set for 2011, but no explanation for the increase is provided. We urge CMS to revisit this and return the meaningful difference amount to the 2011 level or provide actuarial documentation that justifies the increase.

CY 2012 Cost Sharing Standards

Maximum Out-of-Pocket (MOOP) Limits. CMS indicates that it will continue to allow MAOs the option of adopting lower, voluntary MOOP limits and that MAOs will have more flexibility in establishing cost-sharing amounts for Parts A and B services than those that do not elect the voluntary MOOP. ACHP urges CMS to provide a definition or a series of examples to demonstrate what is meant by “more flexibility.” Some of our member plans adopted the voluntary MOOP for 2011 and nevertheless found that such flexibility was not afforded with respect to allowed cost-sharing amounts. While the service category cost-sharing requirements on page 103 of the Call Letter differentiate for plans with and without a voluntary MOOP, we note that plans adopting a voluntary MOOP are only permitted a higher cost-sharing limit for five of the 21 service categories. This alone may not be a meaningful incentive for plans to adopt the voluntary MOOP. We suggest that CMS explore additional approaches to encourage plans to adopt lower, voluntary MOOPs, such as by granting such plans a degree of leeway in complying with the OOPC or TBC thresholds.

Total Beneficiary Cost (TBC). CMS has asked for comments on two approaches being considered with regard to establishing the TBC requirement for CY 2012. Under the first approach, as it did last year, CMS would analyze the distribution of TBC changes after bid submission and identify outliers; CMS would then notify those MAOs with outlier plans that they would need to re-submit an acceptable bid within a limited period of time for that bid to be considered for CY 2012. Under the second approach, CMS would establish an adjusted TBC change amount, based on historical data, and plan bids whose TBC was at or below this amount would not be subject to further scrutiny. However, bids with a TBC above the established amount would be subject to further scrutiny and MAOs might be required to resubmit these bids within a very limited time period. Under this approach, CMS would set the TBC change amount at approximately \$36 per member per month from CY 2011 to CY 2012, although this amount might be altered following bid submission if the distribution of all bids increased program costs more than anticipated.

ACHP supports the second approach calling for a prospective determination of a TBC amount. We believe that this would better facilitate the ability of MAOs to develop their plan cost-sharing parameters and prepare their bids for submission to CMS. We urge CMS to disclose the data and assumptions used to determine the annual TBC and maximum OOPC amounts and to make such information available well in advance of when MAOs need to submit their bids. Similarly, we encourage CMS to provide additional detail on the factors and methodology used to determine and apply the plan-specific adjustments to the TBC amount. Last year, some of our member plans experienced substantial difficulty with the TBC calculation; plans used their internal claims experience whereas the CMS calculation was based on a broader claims experience to which the plans did not have access. For the plans to be able to calculate the measure successfully, they require the same sets of information and data inputs as are used by CMS.

Setting a TBC change amount in advance of bid submission should help ensure that bids are in compliance prior to submission. We expect this will make the bid process go more smoothly for plans and CMS. However, the benefits of this change will be diminished if CMS exercises its

authority to alter the permissible TBC change amount after bids are submitted. ACHP encourages CMS to make TBC changes only in rare circumstances, and to share with plans a list of those circumstances. In addition, we encourage CMS to allow plans ample opportunity – at least three business days – to revise and re-submit non-compliant bids in the event that CMS alters the permissible TBC amount after the initial bid submission deadline.

ACHP suggests that CMS consider sufficient allowance for plans due to the significant variation in how the new payment structure affects different service areas. CMS should account for geographic variations in applying the TBC metric. With the ACA’s change in methodology for calculating the benchmarks, many plans will experience significant effects on their revenues. Congress recognized this impact in doubling the quality bonus payments for “qualifying counties” to moderate the large county benchmark dislocation that occurs in those high MA penetration, urban counties as they transition to the new payment benchmarks. For MA plans to continue to operate in these locales with low underlying fee-for-service rates, it does not make sound policy sense to impose an even greater TBC restriction on them. In effect, the TBC metric may prohibit plans from maintaining financial viability.

In addition, ACHP encourages CMS to take a plan’s margin into account in the TBC determination in order to better ensure more consistent and equitable treatment across MAOs. For-profit MA plans often have a higher profit margin, and therefore have greater ability to implement the member cost reductions requested by CMS. In contrast, most ACHP MAOs are non-profit and already operate with a low profit margin. This made it more difficult for ACHP plans to implement the cost-sharing reductions that CMS requested during the 2011 bid review process without pushing these plans into negative overall margins. ACHP also encourages CMS to make allowances in the TBC calculation for variations caused by plan consolidation, new plan service areas, permitted pairings of plans to meet target margins, and other payment policy issues, such as the lagged SGR fix.

Finally, ACHP seeks clarification on the question of whether MAOs are permitted to include a Part B premium buy-down as part of their benefit package. Page 99 of the Call Letter includes a statement that: “In CY2012, for plans that include a Part B premium buy-down as part of their benefit package, the TBC calculation for that plan will include a factor to account for the additional benefit.” Some MA plans believed that they were not allowed to return Part B premiums to enrollees, and we would like confirmation that in fact they are allowed to do so.

Co-pay Thresholds for Cost Shares

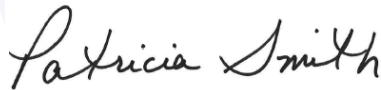
For 2012, CMS plans to conduct an analysis to identify drug tier cost-sharing outliers relative to other sponsors’ competing benefit packages, using the cost-sharing associated with the 95th percentile across all initially submitted bids for plans consisting of three or more tiers. ACHP requests that CMS clarify whether this proposed policy change applies to employer-sponsored Part D plans and/or cost plans with Part D coverage, in addition to MA-PD and PD plans.

CMS Consultation and Assistance during Bid Review Process

To reiterate a point made in our introductory comments, ACHP recognizes CMS' commitment to strengthening beneficiary protections and appreciates that CMS has been more explicit in its requirements and expectations with this Call Letter. However, application of these metrics by CMS and MAOs is still a new exercise and has significant potential for unexpected complications and questions. We urge CMS to provide training opportunities, post FAQs and other clarifications as they are developed and, most importantly, make sufficient national and regional office staff available to work through these legitimate issues with health plans before and after bids are submitted. We understand the difficult timetable, but we hope that CMS will reconsider its statements that plans may not be able to re-submit bids and allow those revisions after initial review and identification of problems by CMS and corrective action by plans.

Thank you for your consideration of our comments. Please let me know if we can provide additional information or answer any questions.

Sincerely,

A handwritten signature in black ink that reads "Patricia Smith". The signature is written in a cursive, flowing style.

Patricia Smith
President and CEO