



January 11, 2011

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4144-P  
P.O. Box 8013  
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 (75 FR 71190-71238)

Dear Administrator Berwick:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to comment on the proposed rule published in the *Federal Register* on November 22, 2010 relating to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit Programs for Contract Year 2012.

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations that collectively 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 cover substantial numbers of Medicare Advantage enrollees. Member plans share longstanding commitments to their communities, 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.

ACHP appreciates the work that CMS has done to implement provisions of the Affordable Care Act to date. In the current proposed rule, we are especially pleased that CMS has moved forward on the Medicare Advantage quality incentive provisions, reflecting Congressional intent to incorporate value-based payment across Medicare. In this letter, we discuss a number of areas where our member plans have expressed concerns about the proposed rule and recommend modifications. These include:

- CMS should provide advance disclosure of the methodology and all specific calculations that CMS will utilize to evaluate and possibly deny plan bids, especially in relation to the calculation of beneficiary cost; transparency and consistency in how these standards are applied to plan bids is essential.
- Future directions for advancing quality improvement objectives, including the demonstration project for quality bonus payments, should focus on improvements in health outcomes, and should lead to quality measures and standards that are aligned among MA plans, fee-for-service providers, and alternative delivery approaches.
- Before moving ahead with the disclosure by MA organizations of customized enrollee data, CMS should address potential inconsistencies among plan comparison tools, in order to avoid

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potential confusion for beneficiaries and minimize the risk of any competitive disadvantage to plans from information that may be misleading.

- CMS should forego release of Part C and D payment data, which our member plans believe is proprietary and its release could allow competitor plans to infer plan sponsor strategy and business decisions. We do not believe that plan payment data will help beneficiaries make informed plan selections.

#### *B.6. Authority to Deny Bids (§422.254, §422.256, §423.265, and §423.272)*

CMS proposes to codify in the MA regulations the provisions of section 3209 of the Affordable Care Act (ACA) which clarify that CMS is not required to accept any or every bid submitted by an MA organization (MAO). CMS may deny a bid submitted by an MAO for an MA plan if it proposes significant increases in cost-sharing or decreases in benefits offered under the plan. Section 3209 also extends these provisions to apply to the review of bids from Part D sponsors. This statutory authority applies to bids submitted for contract years beginning on or after January 1, 2011, but CMS proposes that the regulations implementing this provision be effective 60 days after the publication of the final rule.

CMS applied certain criteria to review plan bids for CY 2011 and is now drawing on the ACA authority to establish additional requirements for CY 2012. CMS proposes that it may by regulation: (1) set specific thresholds limiting premium increases that can be imposed without a bid being denied, (2) limit which MAOs and PDP sponsors may offer plans based on quality ratings, and (3) specify caps on the number or the types of plans that may be offered in a service area. In this regard, CMS has asked for comments on the criteria outlined in the April 16, 2010 guidance and a number of other questions.

**ACHP Comments:** ACHP appreciates the opportunity to comment on proposed changes to the MAO bid process, specifically the criteria outlined in the April 16, 2010 guidance. We support CMS' goal of providing fair notice and equal treatment for all plan bids. However, based on our member plans' experience with the 2011 bid process, ACHP suggests the following changes:

- CMS should provide advance disclosure of the methodology and all specific calculations that CMS will use to evaluate plan bids;
- CMS should be consistent in how these standards are applied to plan bids; and
- CMS should provide additional avenues for MAOs to communicate with CMS during the bid preparation period in order to ensure that MAOs submit bids in full compliance with CMS expectations.

ACHP requests that CMS provide more detailed information about how plan bids will be evaluated in advance of the bid submission deadline. The April 16, 2010 guidance provided partial information in advance of the 2011 bid submission deadline, but the level of detail that was included in this guidance was not sufficient to allow plans to match CMS' out-of-pocket cost (OOPC) calculations. For example, some ACHP plans noticed that CMS seemed to calculate very different OOPCs for similar plan benefit packages, but the plans could not determine how CMS came to these conclusions. ACHP encourages CMS to re-evaluate the OOPC methodology prior to the 2012 bid cycle to ensure that OOPC captures: (1) all Medicare A and B benefits, as well as supplemental benefits where applicable; (2) premium variations, as this is an important factor to distinguish between benefit plans;

and (3) any variations in MA plan Part D benefits, such as the initial coverage limit or formulary design.

In the 2011 bid process, CMS calculated “Total Beneficiary Cost” (TBC) to evaluate bids – a metric that had not been mentioned in the April 16 guidance. Plans were unable to determine how TBC was being calculated by CMS, as well as how TBC related to the calculation of the plan OOPC. If CMS had disclosed the TBC methodology prior to the 2011 bid submission deadline, plans could have ensured that their bids were in compliance prior to submission. This would have made the bid process go more smoothly for both the plans and for CMS.

If the TBC metric is used in future bidding cycles, ACHP encourages CMS to take the plan’s “starting point” margin into account 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 MAOs that are members of ACHP are non-profit and already operate with a very 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 ensure that the TBC calculation makes allowances 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.

In future bidding cycles, it would be helpful for CMS to release a complete list of all metrics that will be used to evaluate bids in advance of the bid submission deadline, as well as information about how these metrics can be calculated by the plans. Specifically, it would be useful for CMS to disclose: (1) how OOPC and TBC will be calculated; (2) what other factors (if any) will be considered by CMS in evaluating plans; and (3) what thresholds CMS will use to identify plan outliers.

Finally, ACHP requests that CMS provide plans with more assistance from the agency during the bid preparation period. For example, it would be useful for plans to be assigned a direct point of telephone contact at CMS, who could facilitate responses to questions about how to simulate CMS calculations when preparing bids. Plans would also appreciate additional training sessions, particularly if CMS releases a new bid tool for the 2012 bid cycle.

#### *B. 20. c. Increases to the Applicable Percentage for Quality (§422.258(d))*

CMS proposes to implement the ACA provisions implementing increases to MA plan benchmarks if they attain four or five stars on a five star rating system implemented by the Secretary, effective January 1, 2012. CMS refers to these payments as “Quality Bonus Payments (QBPs),” and proposes to implement the statutory provisions as designed. At the same time, the agency announces, apart from the proposed rule, implementation of a demonstration of a variant of that proposed rule, applicable for all MA plans for 2012-2014.

In the proposed rule, CMS announces and seeks comments on its intent to transform the five star rating system to “... advance more ambitious and comprehensive quality improvement objectives.” ACHP, which has a long-standing history of promoting high quality care and advancing value-based purchasing, is pleased to comment on those directions.

**ACHP Comments:** ACHP is pleased that CMS is implementing a strong value-based purchasing provision in this rule that reflects the provisions of the Affordable Care Act. This is a significant action to promote high quality care in Medicare Advantage – one which we have long supported – and is consistent with adoption of value-based purchasing approaches across Medicare. We agree with CMS that the quality incentive provisions of this rule should be a first step towards a rating system and other improvements that will facilitate outcomes-based measurement, and we look forward to working with the agency on further reforms that will advance an ambitious quality improvement agenda.

ACHP strongly supports CMS' stated objectives to include greater emphasis on demonstrable improvements in access, health status and outcomes, beneficiary satisfaction and engagement, prevention, management of chronic conditions, and coordination of care. We encourage use of measures that address both quality and cost. For example, the agency might consider measures that focus on transitions in care and use hospital readmission rates as an indicator of how well the transition and post-acute care have been managed. The National Committee for Quality Assurance (NCQA) is developing a Plan All-Cause Readmissions Indicator that should be instructive for CMS' purposes. Similarly, the agency might consider measures of chronic disease management and use both hospitalization rates and emergency department visits for ambulatory-care sensitive conditions as an indicator of primary care and coordination of care for patients with chronic illnesses. The long-term direction should call for an increased focus and weight assigned to these and other measures that better reflect health outcomes.

We have previously expressed to CMS, and reiterate here, our concern that CMS has shifted the star rating system away from clinical quality measures and towards regulatory compliance measures. In addition, we believe there are significant questions about the appropriateness and reliability of the Health Outcomes Survey (HOS) data at the contract level that raise concerns about its use in the star rating system. In general, we believe that the star ratings should reflect an appropriate mix of clinical, patient satisfaction, and compliance measures with an emphasis on clinical (likely HEDIS®) measures. We urge CMS to work with health plans, providers, and patients to reconsider the best mix of measures for the star rating system.

The transformation of the MA rating system should not be designed and implemented in isolation. To achieve "ambitious and comprehensive quality improvement objectives" for all beneficiaries, it is critically important that quality measures, performance standards and any QBP programs be aligned across MA, the original Medicare program, and any other alternative delivery mechanisms that are developed, such as Accountable Care Organizations. The measures should allow comparisons across care systems so that we no longer just compare MA plans with other MA plans, and FFS providers with other FFS providers. From a patient perspective, the measures and standards should be the same; that is the best way to leverage sustained quality improvement in health care.

The alternative QBP demonstration announced by CMS provides an opportunity for learning more as CMS develops this longer-term agenda. We support the special provisions for exceptional performers, including immediate application of the 5 percent bonus to the full blended payment, as well as the Special Election Period for those plans. Because Congress recognized high quality performance at the 4 and 4.5 star level in developing the quality provisions of the ACA, we suggest that CMS consider similar steps that would reward the achievements of those plans and incentivize other plans to reach that level. Finally, we recommend that CMS track and evaluate performance

changes in the demonstration project, and publish those results, especially because the inclusion of the 3 and 3.5 star plans in the quality bonus system had not been envisioned under the statute.

*D.4. Customized Enrollee Data (MA and Part D plans) ( 422.111 and 423.128)*

CMS is proposing to require that MAOs and Part D sponsors periodically provide each enrollee with enrollee-specific data for them to use to compare utilization and their out-of-pocket costs in the current plan year to projected utilization and out-of-pocket costs for the following plan year. Plans would disclose this information to plan enrollees each year in conjunction with annual renewal materials (currently the Annual Notice of Change and Evidence of Coverage (EOC)). Beneficiaries would also continue to be prompted to use other tools such as the Medicare Options Compare (MOC) and Medicare Prescription Drug Plan Finder (MPDPF). CMS is proposing to specify its authority to require such disclosures but is seeking suggestions and comments related to the design, content and cost calculations to assist in implementing these provisions. A pilot program for 2012 with a few MAOs and Part D sponsors may be established to test approaches to conveying customized beneficiary data based on comments.

CMS describes another, “but potentially complementary,” option to require a periodic EOB for MA plans, similar to the EOB that Part D sponsors provide to Part D enrollees. It would include a specific list of services and the enrollee's utilization and out-of-pocket costs during a period of time to assist the enrollee in evaluating options for the future and would be required to be furnished periodically throughout the contract year. CMS seeks comments and suggestions for implementing an EOB for MA enrollees, including suggestions for design, calculation of data and frequency of disclosure to enrollees.

**ACHP Comments:** ACHP appreciates the rationale for providing out-of-pocket cost experience to MA and Part D plan enrollees and giving them a better sense of their potential out-of-pocket costs if they switch to another plan. Before CMS moves forward on this, we urge the agency to address a number of issues regarding the specific information that plans would have to provide to enrollees, in order to avoid giving them confusing information. Confusion could arise as a result of inconsistent information that might be displayed by different plan comparison tools. We are concerned that the out-of-pocket cost information yielded by the different tools will not be comparable. This would happen not as the result of inappropriate or inaccurate calculations of customized enrollee out-of-pocket costs made by a plan, but rather as the result of the application of metrics by CMS in computing projected out-of-pocket costs for enrollees for the MA and Part D plan finder. These metrics may not be sufficiently robust to account for the differences in the way MA and Part D plans make decisions on Medicare covered benefits that are appropriate to the needs of individuals. For example, because of the allowable differences under Part D program rules in the use of prior authorization and other cost-management tools by plans for drugs on their formularies, the plan's enrollee-specific out-of-pocket cost projections may not be the same as those estimated by CMS and displayed on the MPDPF.

Another concern is that any customized enrollee information be limited to the enrollee's out-of-pocket costs for copayments, coinsurance and deductibles. The actual cost for services is immaterial to the enrollee, would be problematic data to assemble and could lead to disclosure of proprietary information such as contractual discounts for hospital services.

Should CMS finalize the requirement that plans provide customized out-of-pocket information to enrollees, ACHP recommends that the out-of-pocket cost data be presented so that it is readily understandable to beneficiaries. In the illustrative tables included in the proposed rule, the level of aggregation shown in Table 6 is the most appropriate if the average amounts spent are restricted to the enrollee's out-of-pocket costs attributable to the plan's cost-sharing requirements, defined as deductibles, co-payment and co-insurance amounts.

With respect to the proposed requirement that MA plans provide an EOB at regular intervals, ACHP appreciates the good intentions behind this proposal as a way of providing enrollees with greater transparency. However, we are concerned about the additional administrative burden for plans, especially if CMS requires the EOB to be provided more frequently than twice per year. In addition, we believe that the EOB could end up confusing enrollees if the information is not meaningful and too granular. Again, we do not believe that beneficiaries benefit from learning the plan's total costs for their services. What is important for the beneficiary is how much they have had to pay in out-of-pocket costs for their services. Thus the information presented on the EOB should be in terms of the enrollee's out-of-pocket costs for the services they have used for the specified portion of the plan year. To reduce administrative burden, the required elements for the MA EOB should be the same as those for the customized enrollee data.

### *E. 3. Release of Part C and Part D Payment Data*

CMS is proposing to release on an annual basis Part C and Part D payment data in the year after the year for which payments were made (and after final risk adjustment reconciliation for MA plans and payment reconciliation of subsidies for Part D plans). A similar proposal was included in the Advance Notice for the 2011 plan year. For Part C, CMS is considering release of payment data summarized at the plan benefit level, specifically average per member per month (PMPM) payments for A and B benefits and average PMPM rebate payments. It is also considering release of the average Part C risk score for each plan benefit package, and aggregated Part C payment data by county. Similarly, CMS is considering release of payment data for Part D summarized at the plan benefit package level as well as average risk score for each plan benefit package. CMS has asked for comment, especially on whether release of payment data at the plan benefit package level would negatively affect the competitive nature of the bidding process or would reveal information that sponsors have provided to CMS that is of a proprietary nature.

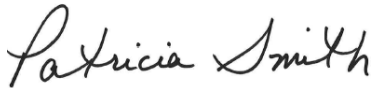
**ACHP Comments:** Transparency in the MA and Part D programs is necessary and desirable to the extent that it facilitates beneficiary understanding of their plan options and facilitates their plan selections. Medicare already requires MAOs and Part D plan sponsors to disclose to CMS and to potential and current enrollees (as well as the public at large) the key information to enable such informed selection. These include such measures of comparative plan performance as monthly premiums, benefits, cost-sharing requirements, formularies and negotiated drug prices in the case of Part D plans, provider and pharmacy networks. These data are also presented in a user friendly format for comparison on the Medicare.gov website. In addition, potential and current plan enrollees may obtain information on how the different plans rate on the CMS star rating system. If CMS implements other provisions in this proposed rule, beneficiaries will have additional tools available to learn about their plan options.

Plan payment data, however, are unlikely to be helpful in aiding beneficiaries in making such informed plan selections. ACHP member plans consider the MA and Part D payment, rebate, and risk score data to be proprietary. Our understanding of what constitutes corporate proprietary data is consistent with how federal law has generally regarded proprietary data. The payment information is not known outside of the plan sponsor's organization. Even then, access to the data is limited to only those employees with responsibility for managing financial aspects of the plan. In addition, MA and Part D plan sponsors take great care to ensure that competitors do not obtain payment, rebate and risk score information. And they apply appropriate administrative, technical, and physical safeguards to protect the proprietary nature of payment-related information.

In this light, we believe that the release of payment related data would have a high likelihood of undermining the competitive bidding process. It would result in the disclosure of MA and Part D sponsor strategy and health plan business decisions. By reviewing two or more years of the data, a competitor may readily determine where their competitors are headed, jeopardizing the fairness and competitive dynamics of the bidding process. We strongly urge CMS to forego any further consideration of release of payment data.

Thank you for consideration of our comments. We would be happy to answer any questions or provide additional information.

Sincerely,

A handwritten signature in cursive script that reads "Patricia Smith".

Patricia Smith  
President and CEO