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January 11, 2011

Donald M. Berwick, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-4144-P Proposed Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

[submitted electronically]

On behalf of the more than 200 members of the Care Continuum Alliance, I respectfully offer the following comments for your consideration in response to the proposed rule on Medicare Advantage and Medicare Prescription Drug Benefit Programs for Contract Year 2012, issued November 22, 2010, in the *Federal Register*.

Care Continuum Alliance members provide services across the entire continuum of care, from wellness and prevention to chronic care and complex case management. Care Continuum Alliance members include wellness and population health management organizations, health plans, physician groups, hospitals, labor unions, employer organizations, pharmaceutical manufacturers, pharmacy benefit managers, HIT service and device suppliers, academicians and others. These diverse organizations share the vision of aligning all stakeholders toward improving the health of populations. Our members seek to improve health care quality and contain health care costs at a population level by providing targeted interventions and services to individuals who are well, at-risk for or already managing one or more chronic conditions or acute episodes of care. Through advocacy, research and promotion of best practices, the Care Continuum Alliance advances evidence-based strategies to improve quality and health outcomes and create efficiency in the marketplace.

General Comments:

In light of CMS' stated goals of strengthening beneficiary protections and identifying strong applicants for participation in the MA program, the evaluation measures for proposed quality bonus payments would be more meaningful with a greater focus on quality and outcomes of beneficiary care versus processes and administrative functions. The move toward outcomes-based evaluation supports increased patient engagement, preventive care, and improved chronic condition management and facilitates overall health care coordination.

The Care Continuum Alliance recognizes that the evolution from the current plan rating system, intended for consumer comparisons, to one that provides quality bonus payments to plans for achieving better patient outcomes will take time. CMS should provide all plans with the

opportunity to achieve higher ratings through incentives and allow resources to be directed to care management and better care coordination.

CMS also should recognize regional and local variations in the delivery and quality of health care.[1, 2] As the Dartmouth Atlas and numerous studies document, health care delivery patterns in the United States vary by locality. With respect to Medicare, articles by Jenks, et al., and others show that the quality of care in the national Medicare fee-for-service program varies tremendously by locale. The federal government recognizes the great disparities in health care delivery across the country by putting programs in place to alleviate the deepest chasms in health care quality. Examples include the geographic payment modified in the Affordable Care Act (ACA) and programs to provide additional support to Health Professional Shortage Areas and Medically-Underserved Areas. Within these parameters, Medicare Advantage plans should be expected to "bend the curve" of health care outcomes upward for their members versus a local mean, particularly those in localities where providers struggle to provide excellent care.

But it is unreasonable to assume that a health plan alone can compensate for a geographic area's manifest disadvantages, including gross shortages of providers, lack of state-of-the-art equipment and training, geographic factors that discourage provider-member contact and socio-cultural barriers. Accordingly, we urge CMS to use evaluation measures that account for geographic differences in provider access, physician practice patterns and beneficiary characteristics.

Care Continuum Alliance recognizes that Special Needs Plans (SNPs) treat Medicare's most vulnerable beneficiaries and have greater care coordination requirements for the Model Of Care. CMS should adjust star rating measures for SNPs to evaluate performance on SNP requirements. CMS also should use outcome-based measurements that compare SNP performance to relevant fee-for-service populations.

In addition, we recommend that CMS revise the star ratings measures applicable to SNPs to better reflect the beneficiary populations that SNPs serve. The reliance of the current system on measures related to preventive health screenings and the treatment of risk factors may not be appropriate for certain SNP populations like those Medicare beneficiaries residing in nursing homes. Clinicians providing care to the fragile elderly may assess certain preventive screenings recommended for the general Medicare population as being potentially harmful and inappropriate. The viability of Medicare Advantage plans designed specifically for special vulnerable populations is threatened by a system that incentivizes actions that are not aligned with the best interests of the beneficiaries they serve.

Several Star HEDIS measures are inappropriate for certain SNP populations, maybe be harmful for others or there may be little or no evidence regarding the effectiveness of certain measures for specific Medicare subgroups. Given the special characteristics of certain populations, we recommend CMS direct the NCQA to exclude: 1) beneficiaries living in an Institutional SNP (ISNP), 2) beneficiaries living in a community who are nursing home certifiable and 3) dual eligible members who have dementia or beneficiaries with chronic persistent mental illness should be excluded from the following HEDIS measures:

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[1] Jencks, SF, Edwin D. Huff, Timothy Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001," JAMA 289(3):305-312 (2003).

[2] Medicare Payment Advisory Commission, "Report to Congress: Regional Variation in Medicare Service Use," Jan. 2011.

- Colorectal Cancer Screening,
- Spirometry Testing to Confirm COPD,
- Glaucoma Screening,
- Osteoporosis Testing in Older Women.

While we recommend these measures be excluded for these conditions, it is paramount that most appropriate and effective care is provided to these vulnerable populations.

Finally, Care Continuum Alliance believes that the proposed Quality Advisory Panel should include external stakeholders to improve evaluation measures for the bonus system. We also recommend pilot or demonstration programs to balance promising quality-indicator measures, like those being developed by RAND (Assessing Care of Vulnerable Elderly – ACOVE), with corresponding implementation challenges.

Specific Comments:

Improvements to Medication Therapy Management Programs (Sec. 423.153)

The Care Continuum Alliance commends CMS for encouraging the use of telehealth and other health information technology tools to improve Medication Therapy Management (MTM). This facilitates health care coordination efforts and positively reflects our shared goal of shifting health care delivery towards a more patient-centered, efficient and high-quality system. In addition, the proposed provision creates greater access to MTM programs for patients in remote locations.

Removing Quality Improvement Projects (QIPs) and Chronic Care Improvement Programs (CCIPs) from CMS Deeming Process (Sec. 422.156)

Regarding the removal of deeming for QIPs and CCIPs, the Care Continuum Alliance encourages CMS to allow plans to maintain flexibility in their programs for quality improvement and chronic care management. CMS oversight of QIPs and CCIPs should preserve the ability of plans to implement innovative programs that address the unique needs of their populations, those with multiple chronic conditions or those who can benefit from wellness programs. As no two populations are alike, no one set of criteria should be applied to quality improvement activities.

If CMS intends to include the evaluation and assessment of these plans into future plan ratings, this process would greatly benefit from collaboration with nationally recognized accrediting organizations, quality experts and the industry.

Special Needs Plans (SNPs) and Dual-Eligibles: Contract with State Medicaid Agencies (Sec. 422.107)

Due to the variation of state contracting and procurement processes, some dual SNPs have experienced increased challenges in obtaining contracts with state Medicaid agencies. The Care Continuum Alliance supports CMS' proposal allowing more time for existing dual SNPs to operate while working to obtain contracts with State Medicaid Agencies.

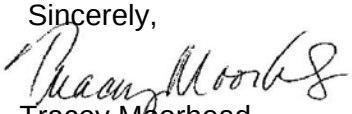
Improvements to Risk Adjustment for Special Needs Individuals with Chronic Health Conditions (Sec. 422.308)

Care Continuum Alliance strongly supports the provisions in the ACA that require the Secretary to improve risk adjustment and to publish the results of studies used to evaluate the improvement of risk adjustment. The Care Continuum Alliance believes that beneficiaries and CMS will be better served by making the payment system more accurate. By improving risk adjustment, CMS would more appropriately create incentives for plans to enroll high-risk

beneficiaries, improve quality and reduce costs. Care Continuum Alliance members have developed considerable expertise on this issue and closely followed CMS activities to implement improved risk adjustment approaches. We would gladly serve as a resource for CMS staff as additional adjustments to this important system are considered.

We appreciate the opportunity to provide these comments and would be pleased to furnish any additional information.

Sincerely,



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