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March 4, 2011

Jonathan Blum
Director, Center for Medicare Management
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 Advance Notice of Methodological Changes for Calendar Year 2012 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2012 Call Letter

[Submitted electronically via: AdvanceNotice2012@cms.hhs.gov]

On behalf of the more than 200 members of the Care Continuum Alliance, I offer the following comments for consideration in response to the Combined 2012 Advance Notice for Medicare released by CMS on February 18, 2011.

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 and hospital systems, 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.

Improvements to Plan Ratings

The Care Continuum Alliance shares CMS's goal of improving the quality of care for Medicare beneficiaries and are encouraged by the increased focus on beneficiary outcomes, beneficiary satisfaction, population health, and efficiency of health care delivery. We support the 2012 proposed enhancements to the quality measures with the inclusion of "all-cause readmission rates," body mass index (BMI), advising smoker and

tobacco users to quit, and medication adherence for Part D plans. In addition, we support the inclusion of measures specific to Special Needs Plans (SNPs) to better reflect the beneficiary populations enrolled in those plans. Further, we strongly support the addition of survey measures for care coordination, care transitions and patient activation in 2013 Plan Ratings. An increased focus on these measures will result in reduced readmissions, greater care coordination, and high patient satisfaction. We encourage CMS to ensure that any new measures include appropriate transparency and lead time for plans to implement changes.

CMS' indication that they will consider plan improvement in addition to achievement relative to benchmarks is also encouraging. We urge CMS to consider geographically appropriate benchmarks to provide all plans with the opportunity to be rewarded for improving quality. CMS should recognize regional and local variations in the delivery and quality of health care. As the Dartmouth Atlas and numerous studies document, health care delivery patterns in the United States vary by locality. With respect to Medicare, research has demonstrated that the quality of care in the national Medicare fee-for-service program varies tremendously by locale.[1] The recognition of Health Professional Shortage Areas (HPSAs) is a good start, but we believe Medicare Advantage plans should be expected to "bend the curve" of health care outcomes upward for their members versus a local benchmark, particularly those in localities where providers struggle to provide excellent care and beneficiaries face socio-cultural barriers to health improvement.

We suggest that CMS evaluate the impact of geographic variation at the conclusion of the 3-year quality bonus demonstration program to determine whether certain areas would be disproportionately impacted and likely to experience MA plan non-renewals if there is not a geographic adjustment made.

Chronic Care Improvement Programs and Quality Improvement Projects

We are concerned with the new requirement for annual submission of Quality Improvement Projects (QIPs) and Chronic Care Improvement Programs (CCIPs) by MA plans including those deemed by an accrediting organization. This change is inconsistent with efforts to reduce administrative burdens and create efficiency where possible. 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.

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

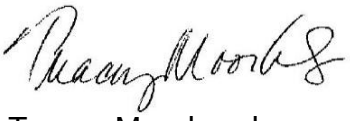
CMS should include nationally recognized accrediting organizations, quality experts and the industry in the development of templates, scoring methodology and benchmarks for QIPs and CCIPs. Additionally, CMS should seek stakeholder comments on drafts, forming advisory groups, and maintain a transparent process. This is especially important if CMS intends to include the evaluation and assessment of QIPs/CCIPs into future plan ratings.

Risk Adjustment
We encourage CMS to continue the evaluation of risk adjustment methodology as directed by the Affordable Care Act to ensure that individuals with multiple chronic conditions and frailty are appropriately accounted for. In addition, we support transparency in the process to revise the risk adjustment system.

Multi-Year Benefits
We agree that multi-year benefits should be atypical in the Medicare Advantage program, but believe that CMS should allow multi-year benefits on any service where traditional Medicare has a multi-year benefit and for supplemental benefits where bi-annual benefits are common in commercial insurance. For example, Bone Mass Measurement (BMI) is only covered once every 24 months and cardiovascular screenings are covered once every 5 years in the FFS program. It is inconsistent with long-established CMS policy to require MA plans to offer benefits to be covered differently in MA than in FFS. Further, multi-year benefits are often used by employers and insurers as a way of extending coverage for important services that are only required intermittently—such as new eyeglass prescriptions. A new requirement to limit benefits to one contract year may result in MA plans discontinuing the offering of some services and we do not believe this in the best interest of beneficiaries.

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

Sincerely,



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