March 5, 2010

Deondra Moseley

Centers for Medicare & Medicaid Services

7500 Security Boulevard, S2-22-25

Baltimore, MD 21244

Dear Ms. Moseley,

The Association for Community Affiliated Plans is pleased to have the opportunity to comment on the Advance Notice of Methodological Changes for CY 2011 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2011 Call Letter. We would like to make comments on the following areas:

Attachment I. Preliminary Estimate of the National Per Capita Growth Percentage for CY 2011

We are disappointment that the estimated growth rate continues to keep the Medicare Advantage rates essentially flat, while medical costs continue to rise. Once again, the rate assumes that there will be a reduction in the payment to physicians, despite the fact that each year the U.S. Congress “fixes” the physician payment rates. This always occurs too late to be factored into plans’ bids, which results in health plans experiencing a loss in this area or not being able to reimburse physicians at a rate competitive with Fee For Service Medicare. We would like to point out that the President’s Budget Proposal includes an adjustment totaling $371 Billion over ten years “to reflect the Administration’s best estimate of future Congressional action based on what the Congress has done in recent years for physician payments. “ We would advocate that the Medicare Advantage Rates anticipate the inevitable Congressional action as well.

Attachment II

Section A. Recalibration and Clinical Update of the CMS-HCC Risk Adjustment Model

The efforts undertaken to improve the CMS-HCC Model’s ability to more accurately reflect future medical expense are applauded. This includes the decision to include new HCCs for dementia, angina, and morbid obesity as well as the recalibration of coefficient values using more recent data. Of concern is the reduction of diabetes HCCs from 5 to 3 which will reduce the risk scores for those individuals with multiple diabetes complications, a population with significant morbidity and mortality.

We support the decision to modify the new enrollee scoring methodology for Chronic SNPs as well as the reduction in the Part C and Part D normalization factors. The coding pattern adjustment we believe inadvertently penalizes SNPs. The 3.41% reduction may help correct payment issues caused by coding differences between the FFS and Medicare Advantage populations as a whole, but it further exacerbates SNP underpayments. SNPs should be treated as a special case because of their specialized role in managing high risk populations and as such should be exempted from this payment reduction.

Section E. Frailty Adjustment

Again this year, we want to point out that nothing in the current risk adjustment methods accounts for limitations in Activities of Daily Living for those MA enrollees who live in the community, but who qualify for institutional level of care. The risk adjustment system must catch up with other efforts to rebalance spending from the nursing to the community. Special Needs Plans can be a key means to provide the care management for these frail elders and persons with disabilities. Payment must reflect the risk of the members enrolled in the plans. We urge CMS to address this area of underpayment.

Attachment VI: 2011 Call Letter

Part D, Section I. Part D Benefits

While we support efforts to encourage curbing waste of unused drugs, the proposed method would be problematic both for sponsors and Pharmacy Benefit Managers (PBMs) to implement, particularly if prorating an LIS subsidy would be necessary. Current systems are not configured to prorate copayments for trial supplies of Part D medications, and building this future functionality, if possible, would be prohibitively expensive.

Thank you for the opportunity to comment. If you have any questions regarding our comments, please address them to me at: 202-701-4749.

Sincerely,

Roberta Brill

Medicare Consultant

Association of Community Affiliated Plans