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March 1, 2013

Mr. Jonathan Blum
Deputy Administrator and Director
Center of Medicare
Centers for Medicare & Medicaid Services
Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Call Letter - Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2014

Dear Mr. Blum,

Care Continuum Alliance (CCA) and our members offer comments on the February 15th CMS Call Letter detailing proposed changes to 2014 Medicare Advantage Methodologies and Payment Policies.

CCA convenes all stakeholders along the continuum of care to improve the health of populations, including individuals who are healthy, at risk of illness, or managing chronic conditions. Through advocacy, research, and education, CCA advances population health management strategies to increase the quality of care, improve health outcomes, and achieve cost-savings. Our diverse membership includes physician groups, nurses, other health care professionals, hospital systems, health plans, wellness and prevention providers, population health management organizations, pharmaceutical manufacturers, pharmacies and pharmacy benefit managers, health information technology innovators, employers, researchers and academics.

We are pleased CMS expressly encourages plans to offer Medication Therapy Management to beneficiaries in the proposed call letter. We also applaud CMS for its efforts to support innovative programs that encourage beneficiaries to adopt and maintain healthy lifestyles by lifting the annual limit on incentives. There is a large and growing body of evidence that demonstrates the power of incentives to increase patient engagement and drive healthy behavior.[1] CCA members also regularly integrate incentives into their efforts to apply proven

[1] Goetzel RZ, Ozminkowski RJ. The health and cost benefits of work site health-promotion programs. Annu Rev Public Health. 2008;29:303-23; Baicker K, Cutler D, Song Z. Workplace Wellness Programs Can Generate Savings. Health Affairs. 2010;29(2):304-11; Volpp KG, John LK, Troxel AB. et al. financial incentive-based approaches for weight loss: a randomized trial. JAMA. 2008;300(22):2631-2637; Volpp KG, Troxel AB, Pauly MV, et al. A randomized, controlled trial of financial incentives for smoking cessation. N Engl J Med. 2009;360:699-709; Seaverson EL, Grossmeier J, Miller TM, Anderson DR. The Role of Incentive Design, Incentive Value, Communications Strategy, and Worksite Culture on Health Risk Assessment Participation. Am J Health Promot. 2009 May-Jun;23(5):343-52; Goetzel RZ, Shechter D, Ozminkowski RJ, Marmet PF, Tabrizi MJ, Roemer EC. Promising practices in employer health and productivity management efforts: findings from a benchmarking study. J Occup Environ Med. 2007 Feb;49(2):111-30; Prochaska JO, Evers KE, Castle PH, Johnson JL, Prochaska JM, Rula EY, Coberley C, Pope JE. Enhancing Multiple Domains of Well-Being by Decreasing Multiple Health Risk Behaviors: A Randomized Clinical Trial. Popul Health Manag. 2012 Feb 21.

techniques of behavior change science in commercially insured populations, with marked success.

The significant new Medicare Advantage (MA) funding reductions proposed in the call letter cause concern for MA market destabilization and unintended consequences to beneficiaries. When added to the reductions already required by the Affordable Care Act (ACA) for 2014, the cumulative reductions result in about an 8% cut in MA funding. If an eventual sequestration is included, this increases to a 10% reduction. These reductions have strong potential to cause disruptions the MA plan market and to MA beneficiaries through unexpected increased costs and decreased benefits to maintain fiscal sustainability. This may result in benefit reductions and premium increases ranging from $600 and $1,080 annually for a typical MA beneficiary next year.[2] Such abrupt funding changes put the MA program at substantial risk of destabilization along with its care coordination efforts, which are critical benefits to contain health costs for chronically ill Medicare beneficiaries. CCA members anticipate that this marked decrease in government support for the MA program may cause several MA plans to disappear from the market.

CCA recognizes that increasing value and cost savings in Federal health care spending are critical in the current fiscal environment. We also appreciate the challenge of identifying cost effective strategies, however there are tangible ways to reduce health care spending in the MA program without shocking the market and MA beneficiaries.

Recommendation: Avert destabilization of the MA market and unanticipated encumbrances on beneficiaries by accounting for the annual Sustainable Growth Rate (SGR) adjustment to the Medicare Physician Fee Schedule.

We strongly encourage CMS to account for impending Congressional action to avert the SGR's projected 30% payment reduction for 2014 in the Medicare Physician Fee Schedule. This is reasonable and consistent with Congressional actions in prior years to stabilize physician payments, by providing a flat payment rate absent a long-term policy solution. Accounting for an SGR adjustment would successfully restore 5% to MA payment rates.

Recommendation: Phase in Fee-For-Service normalization reductions, past restatement of trend, and other rate calculation refinements.

CCA appreciates CMS's work in considering ways to make the Average Geographic Adjustment and the calculation of Fee For Service rates more accurate. We recommend that any refinements should be phased in over multiple years to defray market destabilization.

Recommendation: Omit the proposal to shift star scores closer to the mean and implement changes prospectively, in a manner that gives plans enough time to prepare for changes, to ensure measurement calculations more accurately reflect plan performance.

The proposed changes to the Star Ratings calculation shift overall star scores closer to the mean, or a 3 rating. Our members are concerned that this would cause dramatic shifts in the rating of MA plans, even though the underlying quality metrics of a plan will not have changed. As a result, meaningful differences in plan performance will not be distinguished for

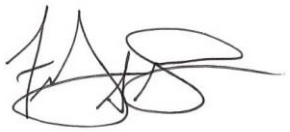
[2] Giese, Glenn and Chris Carlson, "Proposed Changes to 2014 Medicare Advantage Payment Methodology and the Effect on Medicare Advantage Organizations and Beneficiaries," Oliver Wyman (February 2013) http://www.medicarechoices.org/pdf/Proposed_Changes_to_Medicare_Advantage.pdf

beneficiaries.

Plans need a consistent and fair performance approach on which to base investments and drive operational improvement. Similarly, beneficiaries also need consistency in evaluation of plan performance under the Star Ratings to accurately compare MA plans. CCA recommends that CMS omit the proposal to shift star scores closer to the mean to ensure measurement calculations more accurately reflect plan performance. We also recommend that future changes to Star Ratings calculations should be prospective to advance higher quality performance. Currently, CMS publishes updates to its Star Ratings criteria after the time period in which plans are evaluated on those measures. This retroactive assessment and use of data collected as many as three years prior to a plan's Star Ratings determination, create an inescapable lag cycle for plans trying to deploy quality improvements and boost their Star Ratings. Changes in quality within a plan are not reflected in its Star Rating for at least two years. Prospective changes to Star Ratings calculations support CMS's objective of providing an effective Star Ratings program that empowers informed plan selection and will ensure that a MA plan's evaluation is based on known requirements.

In conclusion, CCA appreciates the positive improvements in various portions this call letter around Medication Therapy Management, the annual limit on incentives, and calculating the Average Geographic Adjustment and Fee-For-Service rates. We believe our combined recommendations will help prevent sudden disruptions in the MA market and important beneficiary health benefits, while successfully reducing Federal health care costs associated with the MA Program. CCA would be glad to serve as a resource as CMS refines the proposed changes to 2014 Medicare Advantage Methodologies and Payment Policies.

Thank you for your consideration.



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