March 5, 2018

Liz Richter, Acting Principal Deputy Administrator

Centers for Medicare and Medicaid Services

Director, Center for Medicare

United States Department of Health and Human Services

Hubert H. Humphrey Building

200 Independence Avenue, S.W.

Washington, D.C. 20201

*Submitted via electronic submission system to CMS-2017-0163*

**Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Call Letter**

Dear Ms. Richter:

The Association for Community Affiliated Plans (ACAP) greatly appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the 2019 Advanced Notice and Draft Call Letter.

ACAP is an association of 61 not-for-profit, community-based Safety Net Health Plans located in 29 states. Our member plans provide coverage to over twenty million individuals enrolled in Medicaid, Children’s Health Insurance Program (CHIP) and Medicare Advantage Dual-Eligible SNPs. Nationally, ACAP plans serve approximately one-third of all Medicaid managed care enrollees. Twenty-three of our plans are D-SNPs and 14 of our plans participate in the Financial Alignment Demonstration.

**Summary of ACAP’s Comments**

Please find below a list of ACAP’s comments. ACAP has chosen to respond to a subset of proposals in the Advance Notice that are particularly relevant to Safety Net Health Plans. We submit comments on the following areas: Changes to Risk Adjustment Methodology, SNP Specific Networks, Star Ratings and Social Risk Factors, Opioid Utilization Standards, and Encounter Data.

The positions summarized below are explained in greater detail later in the letter.

* **Encounter Data and Risk Adjustment Data Rates** We agree with CMS’ goal of moving to increased use of encounter data in the risk-adjustment system. We, however, are concerned about how this method disproportionately affects SNPs.
* **Risk Adjustment Methodology.** ACAP supports the addition of more mental health and behavioral health codes to the model. These changes should be made in a way that increases the accuracy of the risk-adjustment model for all subgroups of duals.

* **Improving Beneficiary Communications and Reducing Burden for Integrated D-SNPs**. ACAP strongly agrees with CMS’ proposed administrative alignments for integrated D-SNPs. We applaud CMS’ for taking steps to improve Medicare and Medicaid alignment for D-SNPs and dual-eligible beneficiaries, and for working to encourage states to participate in integrated activities.
* **Opioid Use.** While we are happy that CMS has decided to adopt two out of the three guidelines NCQA has approved, we still believe there is a potential disconnect. ACAP recommends that CMS continue to further align the standards, the CDC guidelines, the PQA measures and the NCQA measures.
* **Network Adequacy Guidelines Specific for SNPs.** CMS indicated that no SNP specific standards will be developed for network adequacy.ACAP would like CMS to reconsider this decision. The purpose of establishing SNP specific networks would be to tailor SNP networks to their target population.
* **Quality Measures and STARS.** ACAP appreciates CMS’ recognition of the ASPE report to Congress, published in December 2016, with its findings showing that dual status is a significant predictor of poor Star Ratings, independent of plan or provider performance. The current Star Rating system fails to adequately account for socioeconomic and disability status, producing a structural disadvantage for plans that serve dual-eligible beneficiaries. We request that CMS develop a meaningful, long-term solution that accurately measures and compares quality of care for plans that disproportionately serve dual-eligible beneficiaries. ACAP believes that stratification could provide a framework for a long-term solution, by ensuring that D- SNPs are compared against other D-SNP plans enrolling a similar population.
* **Health Related Supplemental Benefits.** ACAP is in favor of expanding the definition of a supplemental health care benefit to include those that are specific to daily maintenance and services that diminish the impact of injuries and health conditions.

**Encounter Data and Risk Adjustment**

ACAP wants to thank CMS for creating administrative simplification by offering one system versus two for reporting purposes.

We agree with CMS’ goal to increase the use of encounter data.. We are concerned, however. about how this method disproportionately affects SNPs. According to the studies by Milliman in 2016 and 2017, median EDS risk scores were lower than RAPS risk scores by 4 percent which translated to an approximate reduction of $40/per member per year. Year over year Milliman has found that there is a continued decrease in RAPS risk scores. However, the difference between EDS and RAPs was more pronounced for SNPs, with EDS scores that were 8.4 percent lower than RAPs at the 20th percentile and 5.1 percent lower at the 50th percentile.

ACAP recommends that CMS continue to review the gaps between EDS and RAPS and its impact on SNPs.

**Risk Adjustment Methodology**

ACAP supports the addition of more mental health and behavioral health codes to the model. These changes should be made in a way that increases the accuracy of the risk-adjustment model for all subgroups of duals.

CMS has proposed the choice of two methodologies/models for risk adjustment using a phased in process. Before finalizing a decision on which model is a good fit, ACAP recommends that CMS use 2019 data to gather additional information and continue fine tuning the risk-adjustment process and then use 2020 as the beginning of the phase in.

**Improving Beneficiary Communications and Reducing Burden for Integrated D-SNPs**.

ACAP strongly agrees with CMS’ proposed administrative alignments for integrated D-SNPs. We applaud CMS’ for taking steps to improve Medicare and Medicaid alignment for D-SNPs and dual-eligible beneficiaries, and for working to encourage states to participate in integrated activities. We look forward to continuing to work with the Medicare-Medicaid Coordination Office on finding ways to improve integrated care programs for dual-eligible beneficiaries.

**Changes and Adjustments with Opioid Use Quality Measures**

While we are happy that CMS has decided to adopt two out of the three guidelines NCQA has approved, we still believe there is a potential disconnect. ACAP recommends that CMS continue to further align the standards, the CDC guidelines, the PQA measures and the NCQA measures.

**SNP Specific Network Adequacy Standards**

CMS indicated that no SNP specific standards will be developed for network adequacy.ACAP would like CMS to reconsider this decision. The purpose of establishing SNP specific networks would be to tailor SNP networks to their target population. More flexibility and tailoring for networks is needed, particularly around requirements for the types of providers that must be in a plan’s network and the exceptions process. Not all providers accept Medicaid and therefore there is a high likelihood that these providers will not accept duals.

The time and distance standards for SNP networks should vary based on characteristics and needs of SNP enrollees, including prevailing patterns of care. The requirements on which provider types and the number of providers that must be included in a network should vary and be tailored to the SNP target population. CMS should also change the minimum provider ratio and the beneficiaries required to cover, as appropriate to meet the needs of the target SNP population.

CMS should also permit additional health care delivery modalities, such as telemedicine and mobile units, to be included in the exceptions process. Where possible, CMS should look at how states work through exception processes to promote continued alignment.

**STAR Ratings and Social Risk Factors**

ACAP appreciates CMS’ recognition of the ASPE report to Congress, published in December 2016, with its findings showing that dual status is a significant predictor of poor Star Ratings, independent of plan or provider performance. The current Star Rating system fails to adequately account for socioeconomic and disability status, producing a structural disadvantage for plans that serve dual-eligible beneficiaries. ACAP is pleased that CMS recognizes the problem and is working on interim and long-term solutions.

We recognize that there are many challenges to developing a quality measurement system for MA plans, and one that is not biased by social risk factor. We supported the implementation of the Categorical Adjustment Index (CAI) for 2017. We feel the CAI was a positive step in the right direction. That said, as CMS has acknowledged, CAI is an interim fix and is not a long-term solution. We request that CMS develop a meaningful, long-term solution that accurately measures and compares quality of care for plans that disproportionately serve dual-eligible beneficiaries. ACAP believes that stratification could provide a framework for a long-term solution, by ensuring that D- SNPs are compared against other D-SNP plans enrolling a similar population. We look forward to hearing from CMS about proposed long-term solutions regarding adjustment for socioeconomic status in the Star Rating system. All Medicare Advantage consumers are best served when their plans are evaluated on a level playing field.

The characteristics of the special needs populations should drive quality measures and improvement. ACAP strongly urges a more robust approach to adjust for social risk factors than what is being proposed for the 2019 plan year. When developing a methodology to account for social risk factors in the Star Ratings program, CMS should be guided by the ASPE research findings, as the report provides robust testing and offers methodological options to address social risk factors in Stars.

CMS should use the exceptions and exclusions of individual measures to tailor them to dual-eligible beneficiaries. CMS should also use geographic data at the most granular level possible to adjust for social risk factors and should require measure developers to use this geographic data in measure retesting.

**Health Related Supplemental Benefits**

ACAP is in favor of expanding the definition of a supplemental health care benefit to include those that are specific to daily maintenance and services that diminish the impact of injuries and health conditions. We strongly recommend that CMS convene a group of organizations and experts that represent safety-net plans and whose membership includes duals to gather feedback on the type of benefits that should be authorized.

**Conclusion**

ACAP is prepared to assist with additional information, if needed. If you have any questions, please do not hesitate to contact Christine Aguiar Lynch at (202) 204-7519 or [clynch@communityplans.net](mailto:clynch@communityplans.net).

  
Sincerely,

Margaret A. Murray  
Chief Executive Officer