May 13, 2010

Department of Health and Human Services
Attention: DHHS-2010-MLR
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

To Whom It May Concern,

The Association for Community Affiliated Plans (ACAP) is pleased to have the opportunity to respond to the Request for Comments Regarding Section 2718 of the Public Health Service Act. ACAP represents 50 non-profit Safety Net Health Plans in 25 states providing health care coverage to seven million people through public insurance programs, primarily Medicaid, the Children’s Health Insurance Program, and Medicare. ACAP plans are community-based, partnering with governments to deliver quality health services and provide an essential health care safety net. Among ACAP plans, 21 operate Medicare Advantage Special Needs Plans (SNPs), serving individuals who are dually eligible for Medicaid and Medicare.

The PPACA requires payment of rebates to enrollees if the amount spent on clinical services and quality improvement does not meet minimum standards of 85 percent for coverage offered in the Medicare Advantage market (effective 2014) and the large group market and 80 percent for coverage offered in the small group market or in the individual market (effective 2011).

We would like to comment on the following specific area:

B. Uniform Definitions and Calculation Methodologies
ACAP was proud to support the Affordable Care Act, including the provisions that will establish standards for medical loss ratios for health plans. ACAP believes that health plans’ primary function should be the delivery of high-quality medical care that is best served through care management and care coordination. That is why we applaud the inclusion of quality expenses in the numerator of the Medical Loss Ratio. Our member Dual Eligible SNP’s are required to meet many quality requirements, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS), the Healthcare Effectiveness Data and Information Set (HEDIS), the Heath Outcomes Survey (HOS) as well as CMS administrative data on plan quality and member satisfaction. Congress (through MIPPA) requires that all SNP’s must have in place an evidenced-based model of care that helps the SNP members manage their chronic illnesses and facilitate access to all needed services. CMS requires that each SNP must conduct an initial assessment and an annual reassessment of each member’s physical, psychosocial and functional...
needs; and the SNP’s care managers must develop a plan that identifies goals and objectives for
the member including measurable outcomes as well as specific services and benefits to be
provided. CMS further requires that the SNP must use an interdisciplinary team in the
management of care. ACAP has been consistently supportive of CMS’s requirement that Special
Needs Plans provide these types of services and its member plans have taken their responsibility
seriously (with most plans achieving a 100% score from CMS on their care management plan
design). We believe that the costs associated with CMS-mandated care management programs,
which provide direct ongoing assistance to members, should be included in the MLR definition.

We support the inclusion of care management services, including care coordination and disease
management, in the definition of clinical services. The population served by ACAP Dual
Eligible SNPs is a population which requires extensive case management intervention because it
is sicker and poorer than the general population. Care management services are provided
primarily by licensed clinical health care practitioners and provide specific clinical services.
These include development of plans of care, clinical intervention, health education and working
with the patient’s physician to ensure quality of care. Care managers work with members to
ensure that they keep their medical appointments and refill their prescriptions, contributing to
improved health outcomes. In some cases, plans have developed information technology to
improve coordination of care and for disease management. If it can be shown that the
technology results in improved quality, the costs should be included as quality.

All of our health plans are developing care transitions programs to reduce or avoid readmissions
of their members. Interventions such as coordination between hospital and community staff,
nurse follow-up and home visits by nurses and physicians should be included as clinical costs in
defining the Medical Loss Ratio.

It is important to include as clinical costs those services which result in higher quality care even
when they might also serve to reduce costs. For example, nurse advice lines in which nurses are
available to respond to questions frequently result in reducing hospitalizations. A congestive
heart failure patient who experiences sudden weight gain could potentially avoid a trip to the
Emergency Department if a nurse advice line was able to intervene through a physician or nurse
practitioner increasing the patient’s diuretic. Likewise, certain fraud and abuse activities which
result in the identification of unnecessary or inappropriate services, directly impact the quality
of care received by the patient. On the other hand, costs associated with the identification of
fraudulent billing practices should not be included.

We appreciate the opportunity to comment and are available to answer any questions at (202)
204-7509.

Sincerely,

Margaret A. Murray
Chief Executive Officer