



VNS CHOICE
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May 14, 2010

Frank Horn, Supervising Actuary
State of New York
Insurance Department
One Commerce Plaza
Albany, New York 12257

Mr. Lou Felice
Chair, Health Reform Solvency Impact Subgroup
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: Comments Submitted to Department of Health and Human Services
Regarding Medical Loss Ratio (DHHS-2010-MLR)

Dear Sirs:

VNS CHOICE, a not-for-profit health plan offering Medicare Advantage and Medicaid Managed Long Term Care plans in New York City, submitted comments yesterday to the Department of Health and Human Services, in response to the request for input on the definition of the components of a plan's medical loss ratio. Because of your organization's involvement in this matter, I have enclosed a copy of these comments for your consideration.

If you have questions or would like additional information, please do not hesitate to contact me at 212-609-5640, or by email at kdehm@vnsny.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Karl Dehm', with a long horizontal line extending to the right.

Karl Dehm
Vice President, Operations, VNS CHOICE

cc: Christopher D. Palmieri, President
Judy Duhl, Vice President, Government Relations

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

Attention: DHHS-2010-MLR

To Whom It May Concern,

VNS CHOICE is pleased to have the opportunity to respond to the Request for Comments Regarding Section 2718 of the Public Health Service Act. VNS CHOICE is a not-for-profit health plan in New York City that offers a Medicare Advantage (MA) plan with approximately 5,000 members. Of this group, our Special Needs Plan (SNP) serves 3,500 dual eligibles (people eligible for both Medicare and Medicaid). This plan offers a member-centered approach to health insurance, with a high level of care coordination and a greater use of in-home services than the typical MA plan. VNS CHOICE is an affiliate of the Visiting Nurse Service of New York, the largest non-profit home health agency in the nation.

As you know, Section 1103 of the Health Care and Education Reconciliation Act of 2010, provides that, effective in 2014, if an MA plan does not maintain a medical loss ratio (MLR) of 85%, the plan must pay the excess back to the government. In addition, if a plan fails to have an MLR of 85% for three consecutive years, the Secretary must preclude new enrollment in that plan. If a plan fails to have an MLR of 85% for five consecutive years, the Secretary must terminate the plan. Therefore, the definitions of MLR will have a significant impact on MA plans including SNPs. Accordingly, we would like to comment specifically on the following area:

B. Uniform Definitions and Calculation Methodologies

f. What kinds of special considerations, definitions, and methodologies do States and other entities currently use relating to calculating MLR-related statistics for newer plans, smaller plans, different types of plans or coverage?

We recommend that the MLR definition for MA plans include "care management" activities as a medical service, in order to be consistent with CMS's requirements that SNPs develop and implement a care management program that is designed to actually provide assistance to members.

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 in order to ensure that the members served by plans that provide service to members with complex care needs receive the care management they require.

We further believe that SNPs should be recognized as a “different type of plan” for MLR purposes. Specifically, based on Congressional mandates included in MIPPA and the recently enacted health reform legislation, CMS requires specific and detailed requirements for SNPs that we believe should be recognized as medical care and activities that improve quality when calculating the MLR for SNPs. These requirements include that all SNPs must:

- have in place an evidence-based model of care that helps the SNP members manage their chronic illnesses and facilitate access to all needed services.
- conduct an initial assessment and an annual reassessment of each member’s physical, psychosocial, and functional needs.
- have care manager(s) who 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.
- use an interdisciplinary team in the management of care.

The population served by VNS CHOICE requires extensive care management interventions because the plan’s members are sicker and poorer than the general population. Many have multiple chronic illnesses and multiple physicians who provide ongoing care. 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, management of transitions between health care settings, and ongoing collaboration with the patient’s physician(s) to ensure quality of care.

“Care management” includes care transitions programs to reduce or avoid readmissions of members. Interventions such as coordination between hospital and community staff, nurse follow-up and home visits by nurses and physicians should be included as medical costs in defining the MLR. For example, at VNS CHOICE, our care managers, who are nurses who speak multiple languages, reach out to members to assess their needs and ensure they know how to use the services that are offered. Ongoing interventions are targeted to members who are at risk for hospitalization. The care managers receive support and assistance from a team that includes certified social workers, a pharmacist, and a physician.

While effective care management may have the result of cost containment, this is the outcome of reducing inappropriate utilization that can be wasteful and may be harmful to the member. For example, a care management program which reviews the multiple drugs taken by an older person for negative drug interactions and

intervenes to change the member's medications may indeed result in lower costs, but more importantly would result in a positive health outcome for the individual member. Likewise, nurse advice lines in which nurses are available to respond to questions frequently result in avoiding hospitalizations. For example, a Congestive Heart Failure patient who experiences sudden weight gain could potentially avoid a trip to the Emergency Department if they are able to access a nurse advice line through which a physician or nurse practitioner could intervene to increase the patient's diuretic.

We also applaud the inclusion of quality expenses in the numerator of the MLR. Medicare Advantage plans 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 Health Outcomes Survey (HOS) as well as CMS-mandated quality improvement projects. This information is crucial, and increasingly is publicly reported by CMS and others to benchmark plans against one another, so that consumers can make informed decisions about their health insurance coverage. VNS CHOICE and similar plans have established robust quality improvement programs to meet the unique needs of their members, and the MLR definition should support these activities.

We appreciate the opportunity to comment and are available to answer any questions. Please feel free to contact Karl Dehm, Vice President, Operations, at 212-609-5640, or by email at kdehm@vnsny.org. Thank you.

Sincerely,



Christopher D. Palmieri
President

cc: Karl Dehm, Vice President, Operations
Judy Duhl, Vice President, Government Affairs