

[REDACTED]
November 3rd, 2014

Re: Request for Information about the Impact of Dual Eligibles on Plan Performance

To Whom It May Concern,

Enclosed are [REDACTED] comments and supporting data regarding CMS' request for information about the impact of Dual Eligibles on plan performance.

The data clearly demonstrates the negative impact enrolling a disproportionate share of low-income and disabled beneficiaries has on plan Star ratings. Specifically the data show:

- Plan Star ratings across 17 HEDIS and PDE metrics were negatively impacted by .5 stars in aggregate.
- Utilization for all service categories is disproportionately higher in the Dual Eligible population, yet Star ratings outcomes are significantly lower.
- Dual Eligible screening rates are on par with non-Dual Eligibles, however there is a sharp disparity in triple-weighted outcome measure results.

The causality is attributed to several factors including:

- Increased disease and pain burden in the Dual Eligible population leads to higher rates of extreme polypharmacy and therefore, the potential for lower medication adherence.
- Lower health literacy, a well-known indicator of lower health outcomes, is more prevalent in the Dual Eligible population.
- Lower income impairs [REDACTED] ability to have meaningful educational outreaches with our Dual Eligible membership.

We appreciate the opportunity to respond to the request for information and hope that due consideration will be given to adjusting the Star metrics. We recommend an adjustment so that plans that serve the Dual Eligible population are not unfairly disadvantaged.

Please contact me with any questions regarding this submission or if you would like to discuss our comments any further.

Sincerely,

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Analysis 2: HEDIS Administrative Data (see Figure 2)

Analysis period: CY 2013 (HEDIS 2014) = Data used for 2015 star ratings.

Populations used: Population 1= All non-SNP members in HEDIS sample data, Population 2= All DSNP members in HEDIS sample data.

Statistical significance tested using Z-Test at 95% CI

Stars impact assessed using 2015 Star Ratings cut-points.

Analysis: Again, the DSNP population performed on-par in their screening compliance rate for breast cancer. The DSNP underperformed in two metrics that speak more to disease management (longitudinal compliance), Osteoporosis and Rheumatoid Arthritis management. The final administrative HEDIS metric, plan all-cause readmissions, best illustrates the differences in the two populations as this metric is risk adjusted for readmission likelihood.

Although all but one metric was not statistically significant, the DSNP consistently underperformed their non-DSNP counterparts. This underperformance has cumulative and material negative impact to [REDACTED] overall Star Rating.

Analysis 3: Part D Acumen Data (see Figure 3)

Analysis period: CY 2013 = Data used for 2015 star ratings.

Populations used: Population 1= non-LIS members, Population 2= LIS members.

Statistical significance tested using Z-Test at 95% CI

Stars impact assessed using 2015 Star Ratings cut-points.

Analysis: Due to time constraints, Acumen data segmented by LIS status was used as an approximation for DSNP enrollment. [REDACTED] finds that across all five triple weighted Part D outcome measures, the LIS (a proxy for the DSNP) population underperforms their non-LIS counterparts. Three of the five compliance rates are statistically significant, yet all differences are at least 1 percentage point and a potential for a negative Star Ratings impact.

Impact to Star Ratings

Cumulative impact on our Star Ratings, using 2015 cut-points and weighting are as follows:

Star Rating (weighted) for Non-DSNP and Non-LIS	3.228571
Star Rating (weighted) for DSNP and LIS	2.771429
Difference	0.457143

[REDACTED] assessment of the impact of the Dual-Eligible SNP population is that there is a cumulative and material negative impact of nearly .5 Stars across the 17 clinical metrics that [REDACTED] analyzed.

HEDIS Hybrid Star metrics	(nonSNP) count of compliant	(nonSNP) count of noncompliant	Total	Compliance	Star Rating	(DSNP) count of compliant	(DSNP) count of noncompliant	Total	Compliance	Star Rating	Significant at 95% CI	Stars Weight	Material difference (impacts Star rating)
C01 Colorectal Cancer Screening	195	90	285	68.4%	5	446	175	621	71.8%	5	N	1	0.00
C03 Cholesterol Screening for Patients with Diabetes	198	29	227	87.2%	4	191	35	226	84.5%	4	N	1	0.00
C08 Checking to See if Members are at a Healthy Weight	253	13	266	95.1%	5	175	12	187	93.6%	5	N	1	0.00
C14 Eye Exam to Check for Damage from Diabetes	139	88	227	61.2%	3	157	69	226	69.5%	4	N	1	1.00
C15 Kidney Function Testing for Members with Diabetes	154	25	179	86.0%	4	193	33	226	85.4%	4	N	1	0.00
C16 Members with Diabetes whose Blood Sugar is Under Control	162	65	227	71.4%	3	139	87	226	61.5%	2	Y	3	-3.00
C17 Members with Diabetes whose Cholesterol is under Control	124	103	227	54.6%	4	109	117	226	48.2%	2	N	3	-6.00
C18 Controlling Blood Pressure	182	81	263	69.2%	4	419	224	643	65.2%	4	N	3	0.00

(Figure 1, HEDIS data collected via medical record review)

HEDIS Administrative metrics	(nonSNP) count of compliant	(nonSNP) count of noncompliant	Total	Compliance	Star Rating	(DSNP) count of compliant	(DSNP) count of noncompliant	Total	Compliance	Star Rating	Significant at 95% CI	Stars Weight	Material difference (impacts star rating)
C00 Breast Cancer Screening	3499	1312	4811	73%	0	2917	1082	3999	73%	0	N	1	0.00
C13 Osteoporosis Management	109	147	256	43%	3	53	100	153	35%	3	N	1	0.00
C19 Rheumatoid Arthritis Management	206	46	252	82%	4	208	71	279	75%	3	Y	1	-1.00
C22 Readmission to Hospital within 30 days of Being Discharged	2498	387	2885	11%	3	1454	292	1746	13%	2	N	3	-3.00

National
Average Actual
Readmission
Rate 0.128458
O/E Ratio
nonSNP 0.873
O/E Ratio
DSNP 0.974

(Figure 2, HEDIS data collected from claims)

Part D Metrics	Non-LIS Beneficiaries count of compliant member years	Non-LIS Beneficiaries count of non-compliant member years	Total	Compliance	Star Rating	LIS Beneficiaries count of compliant member years	LIS Beneficiaries count of non-compliant member years	Total	Compliance	Star Rating	Significant at 95% CI	Stars Weight	Material difference (impacts star rating)
D09 High Risk Medication	13394.5	1457.4	14852	9.8%	3	9614	1430.3	11044	13.0%	3	Y	3	0.00
D10 Using Blood Pressure Medications Recommended for People with Diabetes	2716.3	462.5	3178.8	85.5%	3	4832.7	838.1	5670.8	85.2%	3	N	3	0.00
D11 Taking Diabetes Medication as Directed	1713.8	656.5	2370.3	72.3%	2	2351.4	949	3300.4	71.2%	2	N	3	0.00
D12 Taking Blood Pressure Medication as Directed	5931.5	1874.8	7806.3	76.0%	3	7412.1	2896.4	10309	71.9%	2	Y	3	-3.00
D13 Taking Cholesterol Medication as Directed	5264.6	2248.5	7513.1	70.1%	3	6362.1	3019.7	9381.8	67.8%	3	Y	3	0.00

(Figure 3, PDE Data from Acumen 2013 final data)

Analysis of population characteristics

To better quantify the differences in the non-DSNP and DSNP populations, we analyzed member data from July 1st, 2011 through June 30th of 2014 using [REDACTED] engine. Our cohort analysis compared the entire DSNP population [REDACTED] to our largest non-DSNP plan [REDACTED]. Combined, these two plans represent nearly 90 percent of our population, span our entire geographic footprint, and utilize the same network of healthcare providers. Only members current as of June 30th, 2014 and continuously enrolled on the plan for greater than 12 months were included in the cohort.

Business Level Selection

Cohort Name	PBP NUMBER	PROVIDER ORGANIZATION	INDICATOR	COVERAGE TYPE	PCP	COUNTY
[REDACTED]	[REDACTED]	All	All	All	All	All
[REDACTED]	[REDACTED]	All	All	All	All	All

Population Comparison

Cohort Name	Average Age	% Male	% Female	No. of Members
[REDACTED]	63.24	33%	67%	15,105
[REDACTED]	71.39	46.1%	53.9%	17,026

Risk Comparison

Cohort Name	RI	ARI	CGI	RRS(2)	RRS(121)	RRS(125)	RRS(132)	Average # of Comorbidity
[REDACTED]	30.22	35.8	5.58	1.01	1.26	1.30	1.00	4.3
[REDACTED]	23.28	28.13	4.86	0.70	0.93	0.95	0.70	3.58

- The Risk Index (RI) is a numerical representation of the frequency of occurrence of certain risk-predictive "events" within a member's Individual Claim Detail. Each red flag diagnosis, procedure, or drug contributes to the total score. The model considers disease specific criteria, co-morbidities, and treatment patterns.
- The Relative Risk Score (RRS) is a measure of resource use - in total cost or count of outcomes events -relative to an average person. A relative risk score of 1.00 means that the person's risk burden (and predicted cost) is equal to the mean (average) in the development sample.
- The Care Gap Index, or CGI, is designed for point-in-time stratification of care compliance in a population.
- Plan average relative risk model scores are as follows:**

April 2013 to March 2014	2	Medicare All Medical Predicting Concurrent Medical Risk	0.99
April 2014 to March 2015	121	Medicare All Medical Predicting Prospective Medical Risk	1.10
April 2014 to March 2015	125	Medicare All Medical with Util Predicting Prospective Medical Risk	1.12
April 2013 to March 2014	132	Medicare All Medical Predicting 400K Concurrent Medical Risk	0.98

Utilization Comparison

Cohort Name	Admission		Office Visit		ER Visit		Average Length of Stay
	Count	/1000	Count	/1000	Count	/1000	
[REDACTED]	14,401	357.06	394,729	9,786.81	47,698	1,182.61	5.3
[REDACTED]	10,127	216.91	322,711	6,912.19	24,758	530.3	5.5

Our analysis indicates that the Dual Eligible population utilizes services in every care setting, and especially in the acute-care setting, at a higher rate than the non-Dual Eligible population. We also note that the health risk scores are higher due to the higher utilization rates. One assessment of particular interest is that the average number of comorbidities per member is significantly higher in the Dual-Eligible [REDACTED] population.

[REDACTED] also compared the disease burden of both [REDACTED] (nonSNP) and [REDACTED] (DSNP) members using the following [REDACTED] criteria:

[REDACTED] Disease Registry	
Application Name:	[REDACTED]
Cycle Period:	Jul 11 thru Jun 14
[REDACTED]	[REDACTED]
PROVIDER ORGANIZATION	All
[REDACTED]	All
COVERAGE TYPE	All
[REDACTED]	All
COUNTY	All
Analysis Period	Contract Year
Disease Type	All Diseases

The results as illustrated in Figure 4 demonstrate that the disease burden is higher in the Dual-Eligible population in nearly every major acute, episodic, and chronic category. Furthermore, the Dual-Eligible population utilizes services related to these disease states at a higher rate in all but one instance. The Dual-Eligible special needs plan is not afforded the opportunity to focus on one specific disease state when the only common denominator in the population is low income status.

Diseases	Members	Members	Members per 1000	Members per 1000	Office Visits per 1000	Office Visits per 1000	ER Visits per 1000	ER Visits per 1000	Admission per 1000	Admission per 1000
	Current	Current	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
*Hypertension	10,956	11,024	576.1	636.2	7,887.9	10,751.2	721.4	1,408.9	332.1	504.3
Uncomplicated Hypertension	9,047	8,410	473.0	485.4	7,766.3	10,418.4	620.9	1,258.1	276.3	436.4
Hyperlipidemia	7,043	5,663	365.9	326.8	7,881.9	10,950.7	539.1	1,104.5	253.8	383.0
*Diabetes	5,669	6,748	300.2	389.4	8,517.6	11,562.3	798.5	1,529.2	371.9	536.6
Coronary Artery Disease (incl. MI)	3,291	2,815	175.3	162.5	9,173.4	12,554.2	1,037.9	1,944.4	575.6	871.0
Osteoarthritis	3,246	4,624	169.7	266.9	9,365.3	13,123.7	872.3	1,683.5	376.3	555.8
Diabetes Type II w/o complications or unspecified	3,108	3,098	163.3	178.8	7,832.3	10,634.2	639.3	1,233.8	290.6	407.4
Complicated Hypertension	1,909	2,614	103.1	150.9	8,457.0	11,834.7	1,191.6	1,899.7	593.2	725.5
Back Pain	1,866	3,332	95.3	192.3	11,485.3	15,120.9	1,129.1	2,109.3	395.7	531.6
Cerebrovascular Disease	1,857	1,896	102.1	109.4	8,779.9	11,691.8	1,378.7	2,249.5	754.8	1,048.3
Chronic Obstructive Pulmonary Disease	1,805	3,042	99.1	175.6	8,972.5	12,648.9	1,388.7	2,138.1	747.2	899.3
Cancer	1,562	1,156	81.8	66.7	11,055.7	14,919.1	695.0	1,731.6	441.9	838.7
Atrial Fibrillation	1,417	1,108	77.9	63.9	9,586.9	12,456.8	1,238.0	2,070.3	759.2	1,156.6
Diabetes Type II w/ chronic complications	1,334	1,717	70.6	99.1	9,288.4	12,034.2	780.4	1,384.9	383.6	497.5
Congestive Heart Failure	1,182	1,564	68.1	90.3	9,483.1	12,560.9	1,885.7	2,543.9	1,127.6	1,309.1
Chronic Renal Failure	1,049	1,282	57.8	74.0	10,078.4	13,125.9	1,292.8	1,997.8	726.6	975.1
Diabetes Type I	999	1,654	53.9	95.5	9,560.6	12,723.6	1,210.8	2,122.5	576.9	750.3
Osteoporosis	696	587	35.9	33.9	8,406.8	11,433.6	590.3	1,178.3	322.2	482.5
Asthma	569	1,155	29.9	66.7	9,943.3	14,312.1	1,282.0	2,229.0	583.7	676.1
Neck Pain	390	807	19.9	46.6	12,357.6	16,639.0	1,277.1	2,475.7	454.7	614.5
Chronic Liver and Biliary Disease	317	585	18.4	33.8	10,170.8	13,624.1	1,650.4	2,753.5	929.5	1,079.2
Rheumatoid Arthritis	268	450	14.1	26.0	10,987.0	13,016.5	797.0	1,605.2	446.9	524.3
Diabetes Type II w/ non-chronic complications	200	230	10.8	13.3	8,498.8	12,009.3	1,222.5	2,191.1	479.2	923.1
Congenital Anomalies	188	439	10.0	25.3	9,280.3	12,857.1	861.6	1,916.5	508.7	601.9
Skin Ulcer (excl. decubitus)	184	261	9.6	15.1	13,404.8	16,119.8	1,983.9	3,361.3	1,426.3	1,652.7
Major Depression	164	393	8.4	22.7	15,191.9	18,310.6	2,071.1	3,272.7	1,254.8	1,289.3
Major Trauma	163	225	9.3	13.0	10,173.7	14,245.9	2,950.2	4,520.0	1,884.9	1,945.2
Bipolar Disorder	159	451	8.8	26.0	11,340.8	14,388.9	2,819.9	2,996.5	1,159.7	1,141.1
Schizophrenia	127	357	7.0	20.6	8,742.4	11,497.5	1,803.0	2,754.7	878.8	1,075.9
Diseases	Members	Members	Members per	Members per	Office Visits per 1000	Office Visits per 1000	ER Visits per	ER Visits per	Admission per	Admission per

			1000	1000			1000	1000	1000	1000
	Current	Current	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
Acute/Episodic Liver and Biliary Disease	111	219	6.4	12.6	11,716.3	14,907.4	2,937.4	3,258.9	1,869.3	1,453.7
Cirrhosis	88	140	5.3	8.1	9,689.8	11,878.8	1,582.9	2,666.7	1,112.3	1,090.9
Immune Disorders	71	137	4.1	7.9	12,027.0	17,946.8	1,186.5	2,205.3	728.1	1,110.3
Inflammatory Bowel Diseases	70	91	3.6	5.3	8,978.6	12,251.9	1,767.2	2,564.9	769.6	1,007.6
HIV/Aids	65	222	3.5	12.8	7,169.6	9,650.0	729.1	1,748.7	364.6	416.3
Major Organ Transplant	58	63	3.0	3.6	9,840.0	12,958.7	1,200.0	1,983.5	651.4	1,157.0
Ventilator Dependence	54	113	3.3	6.5	9,116.0	12,375.6	3,281.8	5,416.8	2,585.6	3,736.4
Home Infusion	49	117	2.7	6.8	16,642.6	16,093.7	2,714.8	4,128.8	2,045.9	2,547.6
Spinal Cord Injuries	48	71	2.4	4.1	12,583.3	14,053.0	1,291.7	2,255.4	666.7	1,098.8
Demyelinating Diseases	43	101	2.3	5.8	8,061.8	10,871.8	463.3	1,579.5	324.3	512.8
Osteomyelitis	39	71	2.0	4.1	14,575.1	17,040.6	3,553.6	4,754.2	3,296.1	2,663.5
Secondary Diabetes	28	49	1.7	2.8	10,022.0	12,295.8	1,384.6	2,154.9	659.3	1,056.3
Ulcerative Colitis	28	41	1.5	2.4	9,159.8	12,935.1	923.1	3,168.8	781.1	1,194.8
Chronic Pancreatitis	21	54	1.1	3.1	9,937.5	12,769.2	1,781.3	3,500.0	1,218.8	1,153.8
Sickle Cell Anemia	14	34	0.8	2.0	9,000.0	11,679.1	3,750.0	4,235.3	1,200.0	1,219.3
High Risk Pregnancy	4	6	0.2	0.3	16,000.0	10,500.0	1,000.0	0.0	2,000.0	1,875.0
Eating Disorders	3	3	0.2	0.2	7,578.9	2,571.4	4,421.1	1,714.3	3,789.5	3,428.6
Hemophilia	2	5	0.2	0.3	4,500.0	10,800.0	750.0	2,400.0	750.0	0.0
Significant Burns	2	3	0.1	0.2	16,000.0	15,692.3	3,000.0	2,769.2	1,000.0	1,846.2

(Figure 4, [redacted] disease registry)

Impact of Higher Disease burden on Star ratings

A higher disease and pain burden often leads to higher prescribing rates for medications. [REDACTED] analyzed [REDACTED] (nonSNP) and [REDACTED] (DSNP) data using [REDACTED] using the following criteria:

Application Name:	[REDACTED]
Cycle Period:	Jul 11 thru Jun 14
[REDACTED]	[REDACTED]
PROVIDER ORGANIZATION	All
[REDACTED]	All
COVERAGE TYPE	All
[REDACTED]	All
COUNTY	All
Disease Category	All
Secondary Category	All
Individuals	Current
Favorite QRMs	Pharmacy only
Age(Filter by QRMs)	All
Filter:	Pharmacy only>>Current

Data collected illustrates the volume and complexity of pharmaceutical regimens undertaken by our members. Complex drug regimens occur at a much higher rate in our DSNP plan and the complexity of their drug regimens will invariably lead to lower medication adherence.

Description	Individual		Actual
	Total population	With Risk	
[REDACTED] (DSNP) Patients with prescriptions for more than 15 drug classes in the analysis period.	17,757	8,540	48.09%
[REDACTED] (nonSNP) Patients with prescriptions for more than 15 drug classes in the analysis period.	19,879	5,116	25.74%

Low income as a cause of lower health outcomes

CMS asserts that a low income population with an enhanced model of care and Extra Help would have a health status on par, as measured by the Star Ratings, with Medicare Advantage members who do not qualify for low income status benefits. [REDACTED] has not had this experience with our low income population. We assert that the low-income population has a higher disease burden and a lower health status.

Lower health literacy has been directly linked to lower health outcomes in numerous studies²³⁴⁵. Health literacy has been directly linked to lower diabetes management outcomes⁶. Lower health literacy has also been associated with lower physical and mental health⁷.

In order to assess our Dual-Eligible SNP plan members' financial and health literacy status, ██████████ used Health Risk Assessment results collected using an IVR system. All new enrollees, including non-SNP members receive an HRA and DSNP members are assessed at enrollment and annually thereafter. Results are YTD and data available on October 28th, 2014.

Health Risk Assessment questions relating to literacy and poverty	DSNP Response ██████████				Non-SNP Responses				Significant
	Yes	No	Total	%	Yes	No	total	%	
Do you currently have concerns regarding family support, finances, food, or clothing needs?	1373	3478	4851	28%	135	646	781	17%	Y
Would you say that the foods you eat are healthy?	3686	1113	4799	77%	1327	230	1557	85%	Y
Do you have any problems understanding or remembering new information?	1497	3578	5075	29%	316	1344	1660	19%	Y

(Figure 5, IVR HRA Data)

██████████ IVR campaigns

██████████ conducts extensive IVR outreach campaigns in order to educate members and encourage healthy behaviors and preventive screenings. The outreach campaigns include post-hospital discharge outreaches, diabetes educations, member satisfaction and health outcomes assessments, heart healthiness, and medication adherence. We have found that low income directly impacts our ability to successfully outreach to our members. The lower income DSNP members have a statistically significant higher rate of phone disconnection rates as well as higher non-response rates to outreaches.

² Backlund E, Sorlie PD, Johnson NJ. A comparison of the relationships of education and income with mortality: the National Longitudinal Mortality Study. *Soc Sci Med.* 1999;49:1373–84

³ Sorlie PD, Backlund E, Keller JB. US mortality by economic, demographic, and social characteristics: the National Longitudinal Mortality Study. *Am J Public Health.* 1995;85:949–56

⁴ Winkleby MA, Jatulis DE, Frank E, Fortmann SP. Socioeconomic status and health: how education, income, and occupation contribute to risk factors for cardiovascular disease. *Am J Public Health.* 1992;82:816–20

⁵ Adler NE, Newman K. Socioeconomic disparities in health: pathways and policies. *Health Aff (Millwood)* 2002;21:60–76.

⁶ Dean Schillinger, MD; Kevin Grumbach, MD; John Piette, PhD; Frances Wang, MS; Dennis Osmond, PhD; Carolyn Daher, MPH; Jorge Palacios, MA; Gabriela Diaz Sullivan, MD; Andrew B. Bindman, MD. Association of Health Literacy With Diabetes Outcomes, *JAMA.* 2002;288(4):475-482. doi:10.1001/jama.288.4.475.

⁷ Michael S. Wolf, PhD, MPH; Julie A. Gazmararian, PhD, MPH; David W. Baker, MD, MPH. Health Literacy and Functional HealthStatus Among Older Adults. *Arch Intern Med.* 2005;165(17):1946-1952. doi:10.1001/archinte.165.17.1946

Call Details	All Call Results DSNP			All Call Results Non-DSNP		
Attempted		274,496			242,455	
Wrong Number	431			374		
Disconnected	1,374			750		
Busy	2,671			2,613		
No Answer	114,613			72,472		
Unreachable Subtotal		(119,089)	43.4%		(76,209)	31.4%
Reachable		155,407	56.6%		166,246	68.6%

(Figure 6, IVR connection rates)

We attribute the higher phone disconnection and “no answer” rates to lower income and the financial stresses that the DSNP population faces. Lower income, or less discretionary income, could force our Dual Eligible members to lapse in paying their phone bills and effectively end our ability to make timely outreaches.

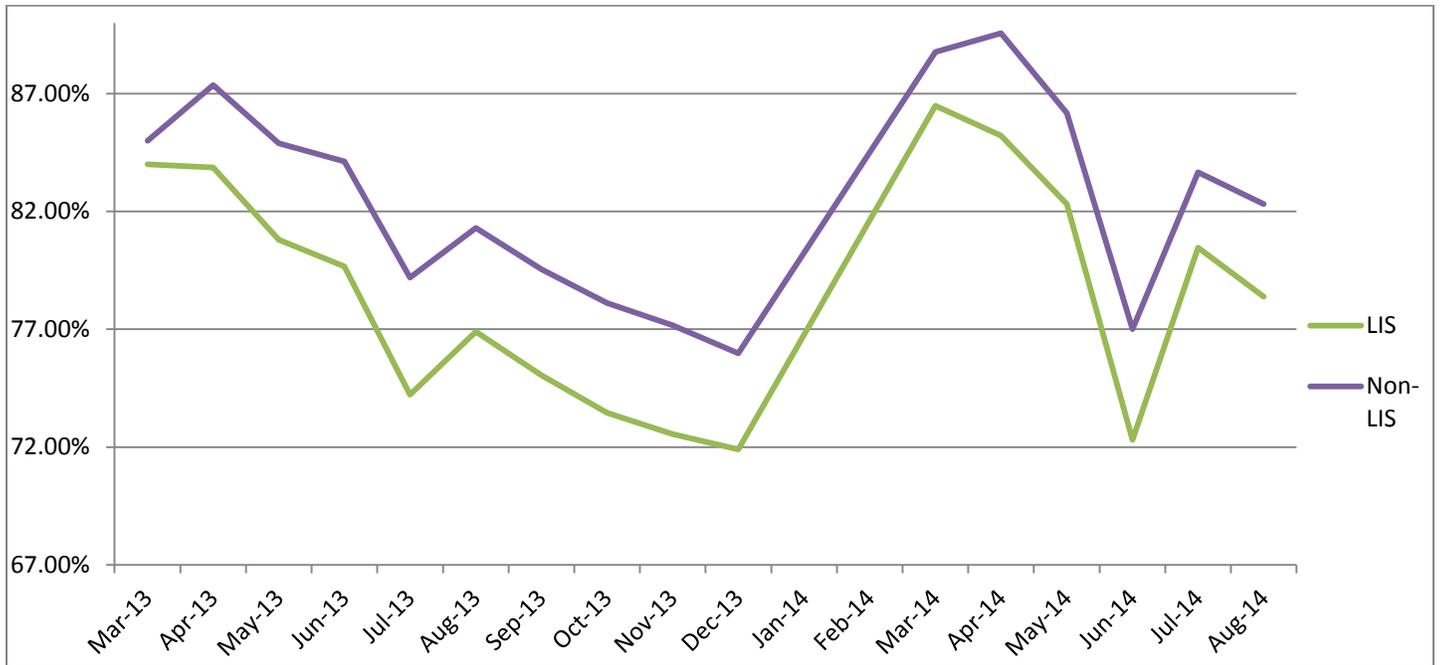
Medication adherence trends

██████ has made concerted efforts to educate our members to the importance of medication adherence. In 2013 we engaged ██████ to perform IVR medication adherence education and prescription fill reminder outreaches on our behalf. We have had significant improvement in our overall medication adherence rates (See figures below), however the LIS membership have consistently underperformed their non-LIS counterparts across all adherence metrics. We attribute this lower performance to our inability to consistently contact our Dual Eligible members.

Diabetes medication adherence (based on Acumen monthly data)



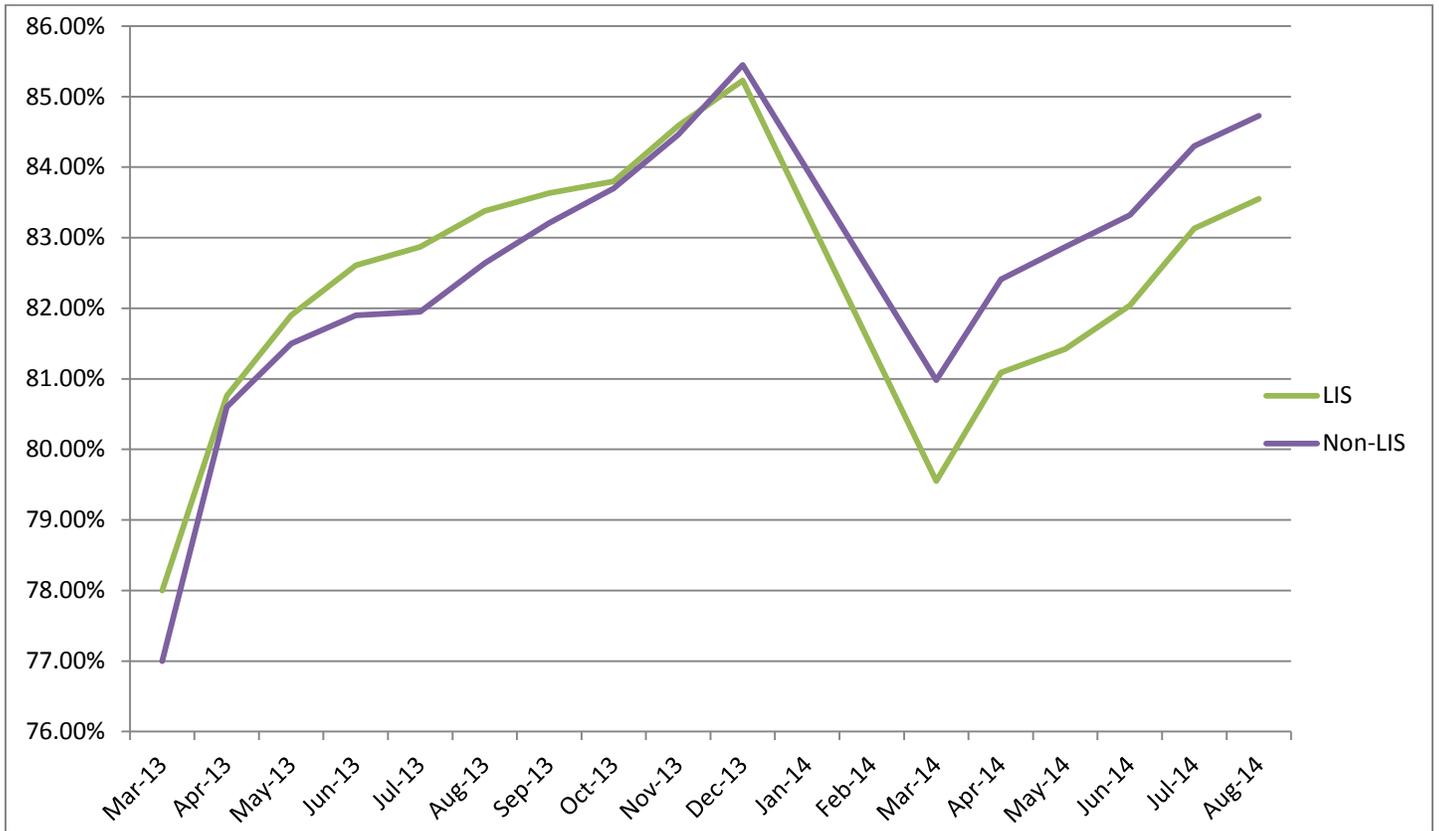
RAS Antagonist Adherence (based on Acumen monthly data)



Statin Adherence (based on Acumen monthly data)



Diabetes Treatment (based on Acumen monthly data)



Conclusion

There is no doubt that Dual Eligible members have a negative aggregate effect on Star Ratings. The data we provided proves causality by linking low income and low health literacy to lower health outcomes. Many additional comprehensive studies outside of a health plan setting have been conducted on this subject and have come to the same conclusion. It is our hope that CMS will use these studies in conjunction with health plan-submitted data to come to develop a methodology to adjust the Star metrics for plans that serve Dual Eligible populations.