UPMC HEALTH PLAN

U.S. Steel Tower
600 Grant Street
Pittsburgh PA 15219
412-454-7500
412-454-7520 (fax)
www.upmchealthplan.com

November 3, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted Electronically via PartCandDStarRatings@cms.hhs.gov

RE: Request for Information – Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees

Dear Administrator Tavenner:

The UPMC Insurance Services Division ("UPMC") is pleased to submit the following comments in response to the above-referenced Request for Information regarding differences in Star Rating Quality Measurements for dual eligible Medicare Advantage beneficiaries.

UPMC, through UPMC Health Plan and the integrated companies of the UPMC Insurance Services Division, is proud to offer a full range of commercial individual and group health insurance, Medicare Advantage, Medicare Special Needs, CHIP, Medical Assistance, behavioral health, employee assistance, and workers' compensation products. UPMC Health Plan serves a combined 125,000 members in its Medicare Advantage and Medicare Special Needs Plans. Over 18,000 of these Medicare members are enrolled in UPMC for You Advantage, the 17th largest dual eligible special needs plan (D-SNP) nationally. Today, UPMC's collective commercial and government program membership exceeds 2 million.

We thank CMS for affording Plans and other stakeholders the opportunity to provide input regarding the unique impact of dual eligible beneficiaries on Plans' Star Ratings. The Star Ratings System and its Quality Bonus Payments are an integral component of ensuring high-quality care for Medicare beneficiaries and rewarding plans for meeting or exceeding the care needs of its enrollees. It is crucial that quality measurement under the Star Ratings system be both fair and accurate – and able to evolve when necessary to best meet its objectives. We believe that the current system does not properly account for underlying differences between dual eligibles and other Medicare beneficiaries.

UPMC supports the Centers for Medicare & Medicaid Services (CMS) in its ongoing efforts to improve the quality and accuracy of the Star Ratings system. It is with this support in mind that we respectfully offer the following comments and analyses.

Introduction

Dual eligibles represent some of the most vulnerable Medicare beneficiaries, including low-income individuals over age 65 and those under 65 with a severe disability. Dual eligibles are more likely to require long-term care, both in institutional and community settings, and experience poverty, homelessness, and other socioeconomic conditions shown to be correlated with lower performance on quality measures.

The stated objective of the Stars Ratings system and quality bonus payments is to improve quality and drive beneficiaries to high-quality plans. While the Medicare Advantage program has made substantial progress towards these objectives, challenges remain with respect to ensuring that such progress includes beneficiaries who have Medicaid coverage in addition to Medicare. Overall, the proportion of enrollees in 4 star plans and above has increased two-fold from 29% in 2012 to 60% in the most recent Stars data released October 10th, and the number of contracts achieving 4 stars and above has increased from 24% to 40% in the same period. On average, over 10% of overall Medicare Advantage enrollment has shifted to 4 star and above plans in each year since 2012.

In contrast, the number of 4 star and above contracts that enroll exclusively (100%) dual eligibles has decreased significantly during the same period from 30% of contracts in 2012 to 11% of contracts in 2015. More importantly, the proportion of dual eligibles enrolled in these high-quality contracts has dropped precipitously from 27% in 2012 to 7% today. This is significant when you consider that enrollment in dual eligible plans has increased 31% in the same period. Simply put, dual eligibles are increasingly enrolling in specialized plans, and those plans are increasingly ineligible for the quality bonus payment and additional resources needed to care for this vulnerable population.

It is tempting to attribute these data to plan sponsors less concerned with quality, or less effective in implementing quality improvements. However, not only do many plan sponsors operate contracts that span the spectrum of star ratings, suggesting this is not a phenomenon attributable to organizational culture, but the disparity in quality scores stratified by proportion of dual eligible enrollment further suggests an important population level difference among plans with dual eligibles. In 2015, 40% of all MA contracts are eligible for a quality bonus payment. Plans with less than 25% enrollment of dual eligibles represented a disproportionate share of these high-quality contracts with 52% 4 star or higher in this stratum. These plans averaged 2% dual eligible enrollment as of October, 2014. In the remaining three quartiles of dual eligible proportional enrollment (50%, 75%, and 100%), no quartile achieved greater than 16% of its plans rated 4 stars or above. The magnitude of this disparity indicates more than organizational differences among plans who achieve high-quality scores and those that do not under the Stars Ratings System.

Distribution of High Quality Contracts in 2015

Proportion D-SNP	**0%**	**0-25%**	**25-50%**	**50-75%**	**75-100%**	**100%**
Number of 4+ Star Contracts	113	143	3	3	3	3
Total Number of Contracts	223	277	30	19	35	27
Proportion of 4+ Star Contracts	**51%**	**52%**	**10%**	**16%**	**9%**	**11%**
Number of 5 Star Contracts	8	10	1	0	0	0
Average Proportion D-SNP	0%	2%	39%	63%	97%	100%
Total Enrollment	7,883,059	12,016,826	979,548	682,284	682,284	283,975
Weighted Enrollment 4+ Stars	**64%**	**68%**	**27%**	**23%**	**23%**	**7%**

UPMC Health Plan routinely identifies and monitors dual eligible beneficiaries enrolled in one of our non-SNP Medicare Advantage plans. As an organization with substantial membership in both non-SNP and D-SNP plans, we believe that we are well-positioned to draw comparisons and perform targeted analysis on dual eligibles without the limitations of proxy by product, or attributing all Medicare Advantage members as non-dual eligible.

Analysis

HEDIS measures are a significant factor in plan performance in the Star Ratings system. Our analysis therefore focused primarily on our performance in closing gaps in care among our dual eligible and non-dual eligible Medicare Advantage members.

Methods

Final CMS measure compliance rates were compared between dual eligible and non-dual eligible members from CY2013 data submitted for CY2015 Star Ratings using chi square and Mantel-Haenszel tests. Members were attributed to categories based on Medicaid enrollment and not by contract number or plan benefit package. Three levels of analysis were completed:

Level 1 – A comparison of dual eligibles and non-dual eligibles was performed to determine if an aggregate or measure-level difference exists between these groups in their gaps of care closure rates. Twenty-seven total measures were examined using both administrative and submission data from CY2013.

A secondary analysis was performed to determine if dual eligibles were less likely than non-dual eligibles to close all gaps in care. A proxy measure of overall gap closure for CY2013 was calculated based on closure in all five of the following measures:

- Colorectal Cancer Screen
- Breast Cancer Screen
- Completion of HbA1C, LDL, eye exam, and nephropathy screen(s) for diabetics.
  Osteoporosis Management
- Rheumatoid Arthritis Drug Therapy

Level 2 – Demographic and lifestyle characteristics were obtained from CMS monthly reporting and a marketing data vendor. Statistical analysis was used to compare overall closure rates between dual eligible and non-dual eligible members stratified by each characteristic to determine if there is an association between dual eligibility and gap closure rate.

Level 3 – Characteristics related to gaps closure were examined in SNP members contacted by an outreach program compared to members not contacted to determine whether certain characteristics within dual eligibles were associated with closing gaps in care. It is important when reviewing these data to note that these members had not closed numerous gaps at the time of outreach during the fourth quarter of the calendar year.

Findings

1. Dual eligibles are less likely to close gaps in care. Of the 27 measures reported to CMS, dual eligibles had lower closure rates on eight measures with statistical significance, and higher rates on four measures. No strong pattern was found between these measures that indicate dual eligibility has an impact on a certain category of measure disproportionate to other categories of measures. The remaining 15 measures did not have differences between dual eligibles and non-dual eligibles at a statistically significant level.

2. Dual eligibles are less likely to close all of their gaps in care. The overall rate of complete gap closure for dual eligible members was 46.2% compared to 52.7% for non-dual eligible members based on administrative rates of the five measures noted above.

3. Dual eligibles closed fewer gaps across all reported measures. The reported closure rate across 27 measures for dual eligibles was 70.7% compared to 72.1% for non-dual eligibles. This is in keeping with published research finding a relationship between dual eligibility and worse performance on quality measures.

4. Dual eligibles were more likely to close gaps in care if they have more pharmacy cost and/or more PCP or specialist visits. Each of these characteristics, which represent more interaction with the healthcare system, was associated with a higher overall gap closure rate on the five measures noted above.

5. Dual eligibles were less likely to close gaps in care if they were non-white or older. Each of these characteristics was associated with a lower overall gap closure rate on the five measures noted above.

6. Dual eligibles are more likely to respond positively to an outreach intervention if they are age 65 or older, male, or associated with a Patient Centered Medical Home (PCMH). All members in our D-SNP are targeted for outreach and education on screenings and gap closure throughout the calendar year, largely through traditional mail. In September of CY2013, a more resource-intensive telephonic outreach was conducted to a random selection of dual eligibles enrolled in our D-SNP who had a large number of remaining gaps in care. The intensive telephonic outreach was successful in closing at least one gap in care in 25.7% of members contacted, compared to 18% of members not contacted, with the above certain characteristics being more strongly predictive of the intervention's success at a member level.

7. Association with a Patient Centered Medical Home (PCMH) was an effective intervention for both dual eligibles and non-dual eligibles, but still resulted in a large disparity between gap closure rates. Association with a PCMH increased gap closure rates 25% for both dual eligibles and non-dual eligibles compared to peers not associated with a PCMH. However, gap closure for PCMH dual eligibles was still 14% lower than PCMH non-dual eligibles (50.5% vs. 57.6%). Also notable is that the disparity in gap closure rates between dual eligibles and non-dual eligibles increased when members were associated with a PCMH (5.5% vs. 7.2%). Plans could reasonably determine that an

intervention such as this has a greater impact on the quality scores of non-dual eligibles, and could potentially direct more of their limited resources toward the population in which they find the highest return, further disadvantaging dual eligibles.

Overall, we found variability in the level of compliance on HEDIS measures in dual eligible members compared to non-dual eligible members. Comparatively lower compliance rates in dual eligible members suggest the presence of disproportionate health care disparities arising from socio-economic factors, for which dual eligibility is a proxy. Alternatively, comparatively higher compliance rates among dual eligibles may be related to more opportunity for gap closure through frequent interaction with the healthcare system.

Policy Recommendations

It is crucial that the most vulnerable populations receiving Medicare benefits are supported by a level of resources equal to their needs. As reflected by our findings, dual eligibles are less likely than non-dual eligibles to close HEDIS gaps in care related to Stars performance, even when participating in resource intensive and costly interventions. Consequently, dual eligibility prevents parity in quality measurement under the current Stars Ratings system.

Plan sponsors are likely to be disadvantaged by enrolling a larger proportion of dual eligibles – a population that requires a higher level of resource investment for relatively less success under the Star Ratings system. Under the current guidelines plans with a disproportionate enrollment of dual eligibles have more difficulty achieving benchmark quality scores and earning quality bonus payments. This is despite the fact that such plans serve precisely those individuals who could most benefit from these additional resources.

In the 2015 Call Letter, CMS stated "Our priorities include enhancing the measures and methodology to reflect the true performance of organizations and sponsors…" Our analysis affirms the already overwhelming evidence that a policy solution is needed in order to achieve Star Ratings system parity and accurate performance measurement for D-SNP and dual-eligible focused Plan Sponsors and the vulnerable beneficiaries they serve. As we noted earlier, the Star Ratings system is achieving its goals with respect to the Medicare population overall, but nonetheless disproportionately disadvantages dual eligibles.

We recommend a simple solution. Compare contracts that enroll a threshold proportion of dual eligibles to other like plans using the current Star Ratings methodology, and set quality thresholds for those plans separately from all other Medicare Advantage plans. Doing so would account for the socio-economic factors widely identified to impact quality scores using a proxy that is easily and currently measured, and which would not require investment by CMS to develop surveys or systems required to implement an adjuster for socio-economic status.

One of our findings across all levels of analysis is that age was a predictor of HEDIS gap closure for dual eligibles. We therefore further recommend that, in the absence of a policy to adjust for differences in dual eligibles at the contract level, CMS implement an aggregate (not measure level) adjuster for dual eligibles over 65, who by definition are low-income, and/or Medicare beneficiaries under 65, who by definition have a severe disability – both factors of which can impact a beneficiary's ability to access adequate care regardless of plan sponsor action.

Thank you for considering our research and policy recommendations. UPMC Health Plan believes that CMS should not lower the bar for quality measurement for dual eligibles and the plan sponsors that serve this vulnerable population, but should take the necessary steps to increase parity under the Star Ratings system for 2015. It is imperative that CMS take immediate action to implement evidence-based policies that account for not only the underlying health differences in Medicare beneficiaries but also the fundamental differences between dual eligibles and the Medicare population at large or risk undermining the viability and quality of plans serving these vulnerable populations.

Sincerely,

John G. Lovelace
President, Government Programs
UPMC Health Plan