BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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SUBMITTED VIA EMAIL TO PartCandDStarRatings@cms.hhs.gov

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Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
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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 Cynthia:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services' (CMS's) HPMS September 9, 2014 memorandum, "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" (Request for Information).

BCBSA represents the 37 independent Blue Cross and Blue Shield Plans (Plans) that currently provide health care coverage to over 105 million Americans. The majority of Plans contract with CMS to sponsor Medicare Advantage (MA) and/or Part D (Part D) Plans in the market today. We are pleased to serve several million Medicare beneficiaries under these two important programs.

BCBSA and Plans support CMS's ongoing efforts to improve the Parts C and D Star Ratings (Star Ratings). We appreciate that the Star Ratings serve multiple functions, including providing beneficiaries information about Medicare plan performance and creating incentives for MA Organizations and Part D Plan Sponsors (collectively, Plan Sponsors) to improve performance. BCBSA and Plans appreciate CMS's sensitivity to the fact that Star Ratings affect MA Plan payment and also can provide the basis for contract termination. BCBSA and Plans are concerned that terminations on this basis will have significant consequences for beneficiaries, such as interruptions in treatment, negative impacts on care coordination, and decreased quality of care.[1]

Given the important role of the Star Ratings under the MA and Part D Programs, it is critical that these metrics accurately capture performance and are not skewed because of the characteristics of the beneficiaries enrolled under a given contract. Accordingly, we support CMS's efforts to closely examine the relationship between the enrollment of a high number of dual-eligible and low-income

[1] See Steven H. Lipstein, MHA & W. Claiborne Dunagan, MD, MS, *The Risks of Not Adjusting Performance Measures for Sociodemographic Factors*, ANNALS OF INTERNAL MEDICINE, Oct. 21, 2014, 161(8), at 594, *available at* http://annals.org/article.aspx?articleId=1890210&guestAccessKey=5cf57c03-0c57-40cd-a0b9-3e6be30f292b for a related point regarding the risk to patients with low sociodemographic status who access providers that may be adversely affected by payment schemes based on performance measures that are not risk adjusted for such status.

subsidy-eligible (LIS) beneficiaries and lower MA and Part D scores in some measures. The National Quality Forum (NQF) – a thought leader in quality improvement and measurement– recently issued a study on risk adjustment for socioeconomic performance in pay-for-performance measures[2] in which the NQF adopted a recommendation that if there is a conceptual relationship and an empirical relationship with the outcome or process being measured, then relevant socioeconomic factors should be included in risk adjustment of the factors "to avoid incorrect inferences about quality based on an overall performance score."[3]

As the comments below explain, BCBSA and Plans believe that having a high number of dual-eligible and LIS beneficiaries depresses MA and Part D Star Ratings. This position is supported by Plans' own analyses and experience and an ever-growing body of research, including the recent Inovalon, Inc. study. In order to appropriately refine the Star Ratings, BCBSA and Plans recommend that CMS adjust the Star Ratings to compensate for the effect of dual-eligible and LIS members under a given contract. There are many factors which CMS should take into account when developing such an adjustment to the Star Ratings, and BCBSA and Plans also recommend that CMS conduct further analysis to determine the best way(s) to adjust these metrics.

1. Analysis Suggests that Having a Disproportionate Share of Dual-Eligible and LIS Enrollees Leads to Lower MA and Part D Quality Measure Scores.

As CMS noted in the Request for Information, numerous entities have demonstrated that there is a relationship between the characteristics of dual-eligible and LIS beneficiaries and Star Ratings scores. Several recent studies suggest that a Plan Sponsor's enrollment of relatively large numbers of dual-eligible and LIS members contributes to low Star Ratings (the Dual-Eligible/LIS Effect). Reviewing such literature, the NQF found that, when performance measures are tied to payment (as is the case with the Star Ratings), the measures should be examined to identify and eliminate disadvantages to health plans serving vulnerable members.[4]

For example, a study published earlier this year in *Health Affairs* demonstrates that certain socioeconomic factors associated with dual-eligible and LIS beneficiaries correlate with low Part D quality performance scores.[5] Specifically, the study found that low-income status, minority status, and the lack of a high school diploma accounted for more than one-third of the difference in Part D contracts' performance scores on medication adherence.[6] Such results are consistent with Inovalon's finding that differences in the medication adherence scores for dual-eligible and non-dual-eligible individuals exist even after controlling for factors including age, sex, region, plan type, reason for entitlement, and CMS MA risk score.[7] Accordingly, it appears that socioeconomic factors associated with dual-eligible and LIS individuals – such as income, housing, and lifestyle – create barriers to care that are reflected in quality measures.

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[2] National Quality Forum, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*, Aug. 15, 2014.
[3] *Id*. at 7.
[4] *Id*. at 11.
[5] Chia-Hung Chou, Eli Raver, Nathaniel M. Rickles, & Gary J. Young, *Socioeconomic Characteristics of Enrollees Appear to Influence Performance Scores for Medicare Part D Contractors*, HEALTH AFFAIRS, Jan. 2014, 33(1), at 140-146.
[6] The three performance scores analyzed were Medication Adherence for Diabetes Medication, Medication Adherence for Hypertension (RAS antagonists), and Medication Adherence for Cholesterol (Statins).
[7] Inovalon, Inc., *The Impact of Dual Eligible Populations on CMS Five-Star Quality Measures and Member Outcomes in Medicare Advantage Health Plans*, Oct. 30, 2013.

Plans' analysis of their own Star Ratings data show similar results. One Plan, for example, found in its analysis a significant increase in the likelihood that LIS members would experience gaps in care as compared to non-LIS members with respect to the medication adherence measures, high risk medication, breast cancer screening, diabetes eye care, and colorectal cancer screening.[8] Such findings demonstrate the negative effect on certain Star Ratings measures created by dual-eligible and LIS members under a given contract. This is consistent with the findings of Ingenix's 2010 study that showed that, although D-SNPs and non-D-SNPs perform on comparable levels for Plan Sponsor performance metrics (*e.g.*, efficiency measures, member complaints, and timeliness of appeals), D-SNPs consistently have lower scores on clinical quality metrics.[9]

Further, information released by Inovalon in October 2014 suggests that the characteristics of dual-eligible enrollees actually influence performance measures.[10] According to the data from one part of Inovalon's three-part study, dual-eligible beneficiaries scored significantly worse on six out of eight current Star Ratings measures: rheumatoid arthritis management, high risk medications, the three medication adherence measures, and plan all-cause readmissions.[11] Notably, there was no significant difference between dual-eligible and non-dual-eligible individuals on the measures of access to primary care. This point is consistent with findings from a 2014 study by the Center for Health Care Strategies, Inc. (and Inovalon's own data)[12] that identified that dual-eligible individuals are more likely to have multiple chronic conditions compared to non-dual beneficiaries.[13]

BCBSA and Plans expect Inovalon to take part in a bipartisan Congressional briefing to discuss their study results and the Dual-Eligible/LIS Effect in general. Inovalon's study is one of the more persuasive in addressing CMS's inquiry as to whether dual-eligible or LIS status equates to lower Star Ratings – there seems to be sufficient support to at least further explore this theory using CMS's expansive data on Medicare beneficiaries. We recommend that CMS carefully review Inovalon's study, briefing materials, and other literature demonstrating the Dual-Eligible/LIS Effect to determine how to adjust the Star Ratings accordingly.

2. <u>CMS Should Develop and Implement an Adjustment to the Star Ratings to Counteract the Effect of Dual-Eligible and LIS Membership and Remove the Disadvantages Created by These Beneficiaries.</u>

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[8] The specific measures analyzed were Medication Adherence for Diabetes Medication, Medication Adherence for Hypertension (RAS antagonists), Medication Adherence for Cholesterol (Statins), High Risk Medication, Breast Cancer Screening, Diabetes Care – Eye Exam, and Colorectal Cancer Screening.

[9] Ingenix Consulting, *The Medicare Advantage Stars Rating System and Dual Eligible Special Needs Plans: Is the Rating System Appropriate?*, Oct. 2010.

[10] Inovalon, Inc., *An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures: Part 1: Member Level Analysis*, Oct. 2014, *available at* http://www.inovalon.com/resource-library.

[11] The specific measures analyzed were Rheumatoid Arthritis Management, High Risk Medication, Medication Adherence for Diabetes Medication, Medication Adherence for Hypertension (RAS antagonists), Medication Adherence for Cholesterol (Statins), and Plan All-Cause Readmissions.

[12] Inovalon, *An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures: Part 1: Member Level Analysis*, Oct. 2014, *available at* http://www.inovalon.com/resource-library.

[13] Center for Health Care Strategies, Inc., *Key Attributes of High-Performing Integrated Health Plans for Medicare-Medicaid Enrollees*, Aug. 2014, *available at* http://www.chcs.org/media/PRIDE-Key-Attributes-of-High-Performing-Health-Plans_090514.pdf.

Plans' experiences and analyses from various sources suggest that having a disproportionate share of dual-eligible and LIS enrollees causes lower MA and Part D quality measure scores. Accordingly, BCBSA and Plans recommend that CMS develop one or more adjustment(s), which can be comprised of one or more mechanisms, to mitigate the Dual-Eligible/LIS Effect. The adjustment(s) should be structured to improve the Star Ratings such that they appropriately account for differences in performance that are caused by the characteristics of the enrollees. This requires that CMS fully explore the parameters of the Dual-Eligible/LIS Effect and various methods to adjust for it.

BCBSA and Plans offer the following considerations for CMS as the agency evaluates the most effective and appropriate adjustment(s):

- ***At what level of dual-eligible/LIS enrollment does the Dual-Eligible/LIS Effect become material?***

  Based on BCBSA and Plans' data and analysis, we are confident that there is a negative effect on Star Ratings when a contract has dual-eligible and/or LIS members. However, we encourage CMS to leverage its access to more extensive and complete data to determine the level at which the Dual-Eligible/LIS Effect can be observed. This threshold may be expressed in terms of the number or percentage of dual-eligible and/or LIS individuals enrolled under a specific contract. A related question then will be at what level an adjustment should be incorporated.

- ***How should the adjustment apply?***

  CMS should consider how to use information regarding the emergence of the Dual-Eligible/LIS Effect to establish the threshold(s) for the application of the adjustment(s). For example, CMS should consider whether the adjustment(s) should be fully implemented at a specific enrollment threshold or whether one or more should be phased in, such that an adjustment's magnitude increases as the number or percentage of dual-eligible and/or LIS enrollees increases.

  NQF recommends a transition period for implementation of recommendations related to socioeconomic factors,[14] and a similar approach could be incorporated with the Star Ratings metrics using the Display Page. Specifically, CMS could use the Display Page to list adjustments to metrics to account for the Dual-Eligible/LIS Effect as part of the agency's implementation of a metric generally.

- ***Does the Dual-Eligible/LIS Effect apply equally to all types of measures?***

  BCBSA and Plans encourage CMS to determine whether having a disproportionate amount of dual-eligible and/or LIS enrollees depresses all performance scores equally. Because dual-eligible and LIS enrollees and the Plan Sponsors that enroll them face certain types of challenges related to their status, BCBSA and Plans acknowledge that specific measures or types of measures may suffer a greater impact than others. For example, measures related to preventative care, which low-income enrollees may see as an avoidable service, may be more susceptible to the negative effects of high dual-

[14] National Quality Forum, *Risk Adjustment for Socioeconimic Status or Other Sociodemographic Factors*, at 8, Aug. 15, 2014.

eligible/LIS membership than measures related to chronic disease management, which may involve more urgent services. As discussed above, multiple studies have shown that dual-eligible and LIS enrollees have lower medication adherence scores, potentially reflecting the economic challenges faced by this population (notwithstanding the availability of Low Income Subsidies under Part D). BCBSA and Plans acknowledge that some measures (*e.g.*, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures) already are adjusted for the case mix of enrollees and may not need further adjustments, while the Health Outcomes Survey (HOS) and Healthcare Effectiveness Data and Information Set (HEDIS) metrics are not case-mix adjusted.

- ***At what level in the calculation of Star Ratings should the adjustment be implemented?***

  Once CMS determines the Dual-Eligible/LIS Effect on measures, the agency should consider where to apply an adjustment. For example, an adjustment potentially could be applied to some or all measures, to some or all domains, or to the final contract score. To the extent that CMS develops an adjustment applicable to specific measures, BCBSA and Plans recommend that CMS consider the weights assigned to those measures that are and are not adjusted and calibrate the magnitude of the adjustment appropriately. For example, the 2015 Part C & D Star Rating Technical Notes state that the improvement measures (Measure C31 – Health Plan Quality Improvement and Measure D05 – Drug Plan Quality Improvement) are given a weight of five. To the extent that these measures are not now adjusted for the Dual-Eligible/LIS Effect, BCBSA and Plans encourage CMS to ensure that the adjustment is large enough to achieve its desired effect despite the heavily weighted improvement scores.

- ***Should the adjustment include different cut points for contracts depending on their level of dual-eligible/LIS membership?***

  BCBSA and Plans recommend that CMS evaluate the potential benefits of setting different cut points (*i.e.* the performance levels which determine the number of stars awarded for a particular measure) for contracts with a high level of dual-eligible and/or LIS enrollees. By adjusting the cut points, CMS may be able to correct the Dual-Eligible/LIS Effect on the "front-end" rather than relying on adjustments after performance scores have been calculated. Such an approach may prove to be more targeted and accurate than an adjustment to a whole measure, domain, or contract score.

- ***Should the adjustment include different cut points for contracts of the same type?***

  Similarly, BCBSA and Plans urge CMS to consider whether there is a benefit to adopting different cut points for each contract type, thus comparing "like" Medicare Plans to one another. For example, MA Plans could all be subject to the same set of cut points while dual-eligible Special Needs Plans could all be subject to a different set of cut points. Such an approach would require that CMS create separate versions of the cut points for each measure influenced by dual-eligible/LIS membership. However, CMS could calculate the cut points using its already established relative distribution and clustering method for each type of Medicare Plan.

We note, however, that many non-SNP MA Plans have high dual-eligible/LIS enrollment, which may run counter to this approach. Again, more data and analysis is warranted.

- ***When should the adjustment be implemented?*** BCBSA and Plans urge CMS to develop and implement the adjustment as soon as administratively possible. Given the implications of the Star Ratings on MA Plan payment and for MA and Part D contract terminations, CMS should seek to develop and implement an adjustment as quickly as possible. BCBSA and Plans note that the adjustment could be announced and implemented even after the data collection period for a contract year has begun, as there would be no changes to the data collected for the measures.

  If the agency is unable to implement an adjustment for the CY 2016 Star Ratings (announced in Fall 2015) for CY 2016 enrollment and CY 2017 payment levels, CMS should at least delay termination of contracts for CY 2016 based on failure to achieve three starts for three consecutive years, in recognition of the Dual Eligible/LIS Effect.

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Thank you for the opportunity to provide comments. In closing, we note that any adjustment CMS implements should not be viewed as a possible mechanism for delivering less than adequate care to LIS and dual-eligible beneficiaries. Adjustments to measures or contracts should be viewed as a reward to those Plan Sponsors that are caring for such vulnerable populations and provided in recognition of challenges created by the socioeconomic characteristics of these beneficiaries (*e.g.*, low education and income) to attaining high scores for certain Star Ratings measures. Similar goals have been achieved through adjustments to the HEDIS measures, and we encourage CMS to consider an analogous adjustment to other measures as appropriate.

BCBSA would be pleased to respond to any question you may have. Questions can be directed to me at Jane.Galvin@bcbsa.com.

Sincerely

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