Commonwealth Care Alliance

November 3, 2014

Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
United States Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted via e-mail to: PartCandDStarRatings@cms.hhs.gov

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

Dear Ms. Tavenner:

Commonwealth Care Alliance (CCA) appreciates the opportunity to offer its perspective to the Centers for Medicare and Medicaid Services (CCA) on the Medicare Advantage Star Ratings as they apply to plans serving duals. CCA has achieved a 4.5 Star Medicare Advantage Star rating for its Senior Care Options program for four years in a row, the only Fully Integrated Dual Eligible Special Needs Plan (FIDESNP) serving only dual eligible members in the country to do so. CCA is proud to have demonstrated consistently high performance, while serving exclusively dual eligible beneficiaries who are primarily frail elderly. Nonetheless, CCA agrees with lower-rated plans serving primarily dual-eligible members that achieving high performance levels on the current set of Star and Display measures is far more difficult and resource intense when serving a population of members with dual status, as compared to a population of non-dual, Medicare-eligible members.

There is a large amount of literature demonstrating the disparities in health care and health outcomes are related to factors common in a Medicaid-eligible population including low income, low education levels, lack of fluency in English, homelessness, and higher incidences of disability, mental illness, substance use, chronic conditions and a combination of the above.[1] Commonwealth Care Alliance's Senior Care Options population shares many of these characteristics, as well as other challenges: 18% are over age 85; 77% are functionally homebound; 60% have less than a high school education; over 60% primarily speak a language other than English and 60% have four or more chronic conditions. The socioeconomic challenges in our member population make those patients harder to engage, often unable or reluctant to go to appointments in traditional office settings and more challenged in complying with medical advice. To even partially overcome these challenges and achieve improved care and outcomes, significant

[1] Please see Shawn Bishop's paper, "Building a Framework for Paying for Social Determinants of Health in Medicare, attached and Inovalon's recently released, "An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star CMS Quality Measures, October 27, 2014.

investments in innovative, high-touch, resource-intensive systems and models of care and care management are required.

Commonwealth Care Alliance's SCO program relies, not only on personalized care plans, but on in-person care management, the inclusion of behavioral health specialists in each member's care team, regular home visits and free transportation to all medical appointments to ensure patient engagement and achieve high quality ratings for its members. CCA also invests heavily in long-term services and supports offered in the home to keep members housed at home and as healthy as possible. Commonwealth Care Alliance spends seven times as much on primary care and community based services and supports, as is expended for the typical fee-for-service Medicaid member in Massachusetts, but cuts hospitalizations for its members in half, since leaving fee for service.

While we at CCA are proud of our high-touch medical model and are convinced that it is necessary for high quality care for dual-eligibles, we also have some circumstances in our favor as compared to other dual eligible plans. First, CCA operates in the health care environment of Massachusetts, which has better organized systems of care than most other states and a much longer history of high quality care and longer focus on quality improvement as well. Second, but even more importantly, CCA has benefited, not only from the Stars premium bonus, but also from additional premium as a result of qualifying for Frailty Adjustment, as permitted for FIDENSPs under the Affordable Care Act. These significant revenue enhancements are essential to properly serving this population, as described above.

As CCA has embarked on serving the under-65 duals population through the Massachusetts Medicare-Medicaid Financial Alignment Demonstration, the challenges noted above are magnified significantly by higher incidences of physical and intellectual disabilities, chronic, persistent mental illness and substance abuse, as well as much less consistency in address and phone numbers. We are concerned about our ability to achieve the high quality outcomes we have achieved for the frail senior duals with the under-65 population. For this population, even greater investment in meeting psycho-social needs and long term services and supports is required before one can achieve high quality medical care and health outcomes. The current quality measurement systems do not measure performance in these non-medical services that are so critical to success with this population.

Under the CMS Star rating system, there is a whole set of characteristics for special needs plans and dual-eligible plans for which the "vanilla" approach to measuring quality and comparing plans does not fairly assess the quality of care and services. There are only a few measures in the CMS measure set that are particularly relevant to the special needs and dual-eligible populations, populations that may have large numbers of individuals that are very elderly, frail, have significant physical or developmental disabilities, severe mental illness, and who face significant socioeconomic challenges.

The current rating system unfairly penalizes duals plans through the Star rating itself, and perhaps more importantly, by making it far less likely that a dual plan will receive the premium bonus tied to a high Star rating. In this way the current system unfairly penalizes those plans that need the higher premium most in order to make the high investments in care and care management required to achieve high performance in the populations with significant barriers related to significant socioeconomic challenges and high rates of frailty, physical or developmental disabilities, and severe mental illness.

For the CMS Five Star Quality Rating System to provide a level playing field for special needs plans and dual-eligible plans, "risk adjustment" of results for certain socioeconomic and population variables measures is required.

The Inovalon study cited above and touted by the SNP Alliance, ACAP and others has concluded that the current "apples to oranges" CMS rating system could have a significant negative impact on dual-eligible and special needs plans and the people they serve. CCA agrees with this conclusion. In general, lower star ratings result in lower payments. Lower ratings could mean that benefits and services available to members may be lowered. Lower ratings may also force plans to stop serving these groups all together, leaving that population with fewer choices for their health care.

Although many solutions to the ratings system are being discussed, we believe that dual-eligible and special needs plans should be rated separately from Medicare Advantage plans that serve wealthier and healthier members. Such a change would account for population differences in key socioeconomic status variables and include measures that target important aspects of caring for our unique populations, like transitions of care management, behavioral health and primary care integration and appropriate use of long-term services and supports. There should also be more measures specific to the most prevalent chronic conditions of members of special needs plans and dual-eligible plans.

"Apples to apples" comparison will ensure that plans are evaluated on how well they are serving their members and help promote and protect access to high quality care for the patients who need it most.

We appreciate the opportunity to provide our perspective at CMS considers the important question of the relationship between dual status and quality measurement and payment incentives. We would be happy to discuss our experience in more detail.

Sincerely,

Lois Simon

Lois Simon
President

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