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SUBMITTED ELECTRONICALLY TO PartCandDStarRatings@cms.hhs.gov

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I. About MCS Advantage Inc.

MCS Advantage Inc	Enrollees Oct 1st 2014	Distribution
Non-Dual (MAPD)	71,464	41%
Dual (D-SNP)	76,979	44%
EGWP (MAPD)	27,725	16%
Total	**176,168**	**100%**

MCS Advantage Inc (MCS), subsidiary of Medical Card System, Inc, has been operating as a Medicare Advantage plan since 2005. As of October 2014, MCS Advantage Inc serves over 176,000 MA beneficiaries in its products, 44% of which are dual eligible beneficiaries. MCS is part of the **Medicaid and Medicare Advantage Products Association (MMAPA)** (www.mmapapr.com) and of the local multi-stakeholder effort named the **Puerto Rico Medicare Coalition for Fairness** (www.prmedicarecialitionforfairness.org).

IMPORTANT: Our response includes the following appendices which are important part of our response.

Appendix 1 – Response send by the ***PR Medicare Coalition for Fairness***. Key elements of our response make reference to the contents in the response sent by the Coalition.

Appendix 2 – This is an excel file with 6 tables comparing MCS Advantage Inc. STARs measures performance and 1 summary table.

Additional Data – MCS can provide all the additional data and information sources as needed by CMS. Please contact us for the submission of any additional information used in the preparation of this report.

II. General Definition of Population Sub-Groups as Applied to Puerto Rico

As per CMS' RFI, the analysis included herein is focused on providing empirical evidence that demonstrates the relation between socio-economic status and performance in the current STAR rating program. Still, the dual/non-dual relation in Puerto Rico is not equivalent to the comparison of distinct socio-economic categories as it is in other jurisdictions. Instead, we have defined 3 distinct socio-economic status categories that can be identified in the MAPD products of the island. An elaborated description and definition of the categories is being included in the join submission of ***MMAPA*** and the

PR Medicare Coalition for Fairness (***See Appendix 1***). The categories and descriptions in said submission to the RFI are the same ones used by MCS here.

In general:

(1) Dual = Beneficiaries in the D-SNP products of MCS.
- All of these plans are part of the integrated Medicare-Medicaid program contracted with the local government called Medicare Platino.
- To be eligible beneficiaries have to be 87% FPL or below.

(2) Non-Dual = Beneficiaries in MAPD plans of MCS that are non D-SNP and non-EGWP.
- For the reasons elaborated in ***Appendix 1***, this population is largely composed of low income beneficiaries between 87% FPL and 150% FPL.
- Beneficiaries in this category have the most harmful scenario with regards to the combination of low income levels with high out of pocket costs.
- Being barely over Medicaid eligibility in Puerto Rico (87% FPL) these beneficiaries are statutorily excluded from the Part D LIS which produces higher level of copays for prescription drugs relative to similarly situated individuals in other jurisdictions.
- Aggravating factors that impact access by affecting out of pocket costs (OOPCs) include the exclusion of Supplemental Security Income (SSI) and the inexistence of the extra help of Medicare Savings Programs for Part B premium and cost-sharing support.

(3) EGWP (Employer Group Waiver Plans) = Beneficiaries in EGWP plans of MCS.
- At MCS, these beneficiaries are mainly beneficiaries that get additional employer contribution as retirees of [redacted].
- These beneficiaries are regarded as a concentrated group of higher income, higher education individuals.
- The employer contribution also impacts access as it mainly helps to pay for any additional member premium and for lower cost-sharing levels.

Please refer to ***Appendix 1*** for more support and detail about the definition of the socio-demographic characteristics of these 3 plan categories identified in the MA program for Puerto Rico.

III. Specific Intra-Plan Analysis for MCS Advantage Inc

In order to present empirical evidence, a statistical analysis of data by category was performed to document and measure the following:

(1) The specific level of compliance (performance) for a group of 16 STAR rating measures was calculated for the sub-groups defined: Dual, Non-Dual and EGWP.

(2) The results for each group were compared and a statistical difference test was performed for each measure.

(3) For each measure, we also calculate the relative probability (odds) of compliance for one group against the other.

(4) These tests were performed using MCS advantage membership data that was valid for the 2015 CMS STAR rating. Two samples were tested, (a) all members, and (b) members with diabetes diagnosis only. We selected the group of beneficiaries diagnosed with diabetes to limit the possible confluence of variables due to differences in health status.

Data Studied

MCS Medicare Advantage products that were eligible for the Stars Rating for 2015 were selected (**See Figure 1**) and divided by the type of MA Part D Groups that they were enrolled during that contract year. For the second set of analysis, the same initial group was filtered to select only enrollees diagnosed with diabetes, and later divided by the type of population group (by plan type) that they were enrolled during the evaluated period. (**See Figure 2**)

Figure 1: Distribution of the MCS MAPD Enrollees between the Main Comparison Groups

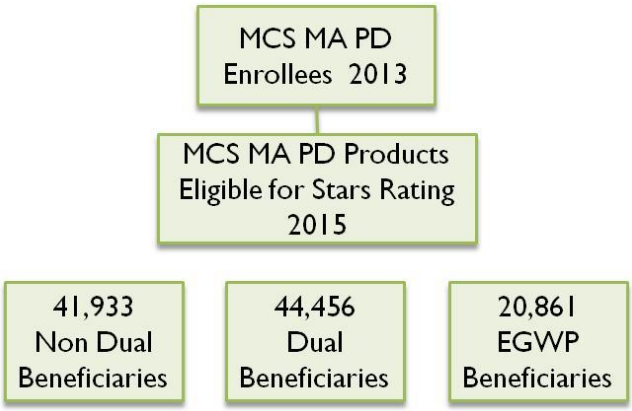
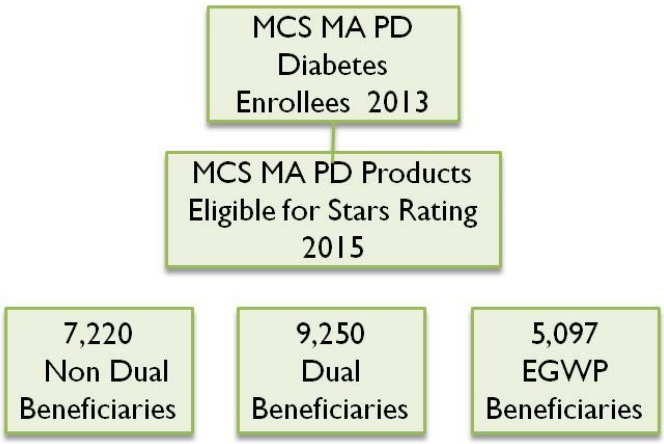


Figure 2: Distribution of the MCS MAPD Enrollees with confirmed a diagnosis of diabetes



Data Sources

In order to create the data Base that was used for this analysis a merge was done form several data sources.

Part C and Part D Measures: A report was provided from the MCS Premium Management Area, which contains all the HEDIS measures, medication adherence, and high risk medication measures used for the Stars Rating analysis by beneficiary. The beneficiary number was used to merge additional information and organize the results for members under the 3 defined categories: Dual, Non-Dual, EGWP.

The table below lists the measures used for the comparison of STAR performance across population subgroups.

Table 1: Stars Rating Measures utilized for the analysis[1]

Measure	Measure name
C01*	Breast Cancer screening
C01	Colorectal cancer Screening
C02	Cholesterol Management for Patients With Cardiovascular Conditions
C03	Comprehensive Diabetes Care
C05*	Glaucoma Screening in Older Adults
C08	Adult BMI Assessment
C13	Osteoporosis Management in Women Who Had a Fracture
C14	Comprehensive Diabetes Care Eye Exam Retinal Performed
C15	Comprehensive Diabetes Care Medical Attention for Nephropathy
C16	Comprehensive Diabetes Care HbA1c poor control
C17	Comprehensive Diabetes Care LDLC control
C19	Rheumatoid Arthritis Management
D09	High Risk Medication
D11	Part D Medication Adherence for Oral Diabetes Medication
D12	Part D Medication Adherence for Hypertension
D13	Part D Medication Adherence for Cholestrol Statins

At the individual member level, all variables selected for this analysis were categorized in Compliance, Non Compliance, and Not Applicable. As mentioned before the measures under consideration for this analysis are the ones collected through HEDIS and prescription drug events (PDE), since these are the only measures that can be tracked to specific beneficiaries within each sub-group analyzed.

Statistical Analysis

Differences between groups

[1] Breast Cancer & Glaucoma ScreeningMeasurement were not used in Stars Rating 2015 however since the data was available for the 2013 beneficiaries they were calculated for the purpose of this analysis.

In order to prove that the groups of beneficiaries (Dual, Non Dual and EGWP) differ in their performance for the 16 quality measures under study three lines of comparisons were created:

(1) Non Duals vs. Duals
(2) Non Duals vs. EGWP
(3) EGWP vs. Duals

All the quality measure variables are dichotomous (comply/ no comply) in nature which will present the analysis as a 2x2 contingency table for the line of comparison and each one of the measures of interest.

Figure 3: 2x2 contingency table example

	quality measure		
groups	comply	no comply	total
1	a	b	a+b
2	c	d	c+d
total	a+c	b+d	

When working with categorical data the suggested statistical test to prove differences between the groups would be a chi-square test for homogeneity [234] with 1 degree of freedom which follows this general hypothesis:

H_0: The two populations under study are homogeneous with respect to the compliance in the quality measure.

H_1: The two populations are not homogeneous with respect to the compliance in the quality measure.

All the analyses were performed with a confidence level of 95% (α=0.05). The analyses were performed using IBM SPSS Statistics version 20 as the statistical package. Chi-square formula:

Figure 4:

Chi-square formula	
$X^2 = \sum \left[\frac{(o_i - E_i)^2}{E_i} \right]$	O_i= observed cases frequency
	E_i= expected cases frequency

[2] Elliot, A. Woodward, W. (2006) Statistical Analysis Quick Reference Guidebook: with SPSS Example.
[3] Daniel, W. (2008) Biostatistics: A Foundation for Analysis in the Health Sciences
[4] Daniel, W. (2000) Applied Nonparametric Statistics

The test was performed for all combinations (line of analysis by quality measure) for the two main populations (total beneficiaries and diabetes diagnosed beneficiaries).

Risk analysis for the 2x2 contingency tables

After performing the chi square test the other main objective of this analysis was to assess the odds (probability) of one group performing different than the other for each measure. For this purpose a risk analysis for the 2x2 contingency table was performed using the same contingency tables created for the first part of the analysis. In epidemiologic terms this analysis is a retrospective one since the outcomes have already occured[5][6]. For this reason the risk measure would be the odds ratio (OR).

Figure 5: Odds Ratio formula (OR)

Odds ratio formula	
$\boldsymbol{OR = \frac{(a/b)}{(c/d)} = \frac{ad}{bc}}$	(a/b)= observed odds of having the outcome for group 1
	(c/d)= observed odds of having the outcome for group 2

For the purpose of this analysis the main interest is to see if the **OR** is statistically different than 1 since 1 represents no differences in the odds of compliance with the metric. If the OR is greater than 1 it provides evidence for group 1 having greater odds to comply than group 2. If the OR is less than 1 then it would mean that group1 has fewer odds to comply with the measure than group 2. To calculate the magnitude of the odds then we will subtract 1 from the OR results.

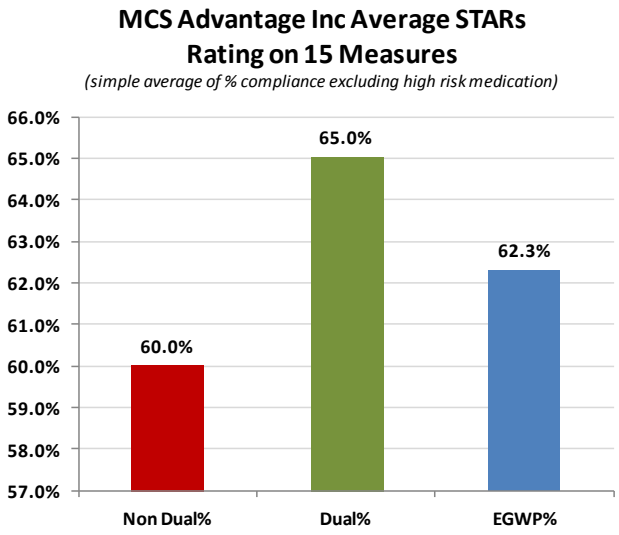
To assess statically significant difference than 1 in the OR we use the Confidence Interval (CI) provided when calculating the risk analysis. This will be made analyzing the presence of 1 inside the CI. The confidence level was 95% and the statistical package utilized was IBM SPSS Statistic version 20.

The risk analysis was performed for all combinations (line of analysis by quality measure) for the two main populations: **(1)** total beneficiaries, and **(2)** beneficiaries diagnosed with diabetes.

[5] Elliot, A. Woodward, W. (2006) Statistical Analysis Quick Reference Guidebook: with SPSS Example.
[6] Gordis, L. (2013) Epidemiology 5th Edition.

IV. Results of the Comparison of Performance by Category

- The comparisons by individual measures of the 3 category groups evaluated reflected a significant lower level of performance for the non-dual population. This result is aligned with the characteristics of this population as described in ***Section 2*** and in ***Appendix 1***. The non-dual population in Puerto Rico is largely low income and pays the highest OOPC in MAPD plans of any of the 3 groups evaluated.



- On the other hand, the dual group reflected the highest level of compliance, supported by the lowest levels of cost-sharing and a focused extra effort on individual care plans and care coordination.

- The comparison of the EGWP vs non-dual performance within the MCS Advantage plans does present evidence that socio-economic factors are influencing quality performance. EGWPs and non-dual plan options at MCS have more similar delivery model characteristics and higher cost-sharing in core benefits (physician, prescription drugs) compared to dual products. Given the similarities, EGWPs tend to have higher performance than non-duals.

- In ***Appendix 2*** we include the detailed calculation of significance and probability of compliance by measure.

MCS Advantage Inc Average STARs Rating on 16 Measures Compared

Measure	Measure name	Non Dual%	Dual%	EGWP%
C01*	Breast Cancer screening	78.2%	84.3%	79.2%
C01	Colorectal cancer Screening	62.6%	71.5%	62.9%
C02	Cholesterol Management for Patients With Cardiovascular Conditions	95.2%	93.9%	95.2%
C03	Comprehensive Diabetes Care	92.8%	92.3%	94.0%
C05*	Glaucoma Screening in Older Adults	68.9%	75.3%	76.3%
C08	Adult BMI Assessment	79.9%	91.4%	73.7%
C13	Osteoporosis Management in Women Who Had a Fracture	22.6%	24.1%	25.2%
C14	Comprehensive Diabetes Care Eye Exam Retinal Performed	58.8%	61.6%	64.6%
C15	Comprehensive Diabetes Care Medical Attention for Nephropathy	88.0%	91.7%	90.5%
C16	Comprehensive Diabetes Care HbA1c control*	16.8%	16.4%	14.9%
C17	Comprehensive Diabetes Care LDLC control*	9.8%	12.2%	8.2%
C19	Rheumatoid Arthritis Management	54.7%	60.3%	57.6%
D09	High Risk Medication	9.8%	14.4%	11.4%
D11	Part D Medication Adherence for Oral Diabetes Medication	60.7%	71.7%	67.7%
D12	Part D Medication Adherence for Hypertension	67.0%	72.9%	72.9%
D13	Part D Medication Adherence for Cholestrol Statins	44.2%	55.9%	51.6%
Avg	**Average** *(excl. D09)*	**60.0%**	**65.0%**	**62.3%**

** Rates based on administrative data only since those are hybrid measures for public reporting.*

(1) Comparison of performance of duals vs non-duals

		All Beneficiaries		Diabetics Only	
Measure	**Measure name**	**Significant Difference?**	**More odds to comply**	**Significant Difference?**	**More odds to comply**
C01*	Breast Cancer screening	YES	duals	YES	duals
C01	Colorectal cancer Screening	YES	duals	YES	duals
C02	Cholesterol Management for Patients With Cardiovascular Conditions	NO		NO	
C03	Comprehensive Diabetes Care	NO		NO	
C05*	Glaucoma Screening in Older Adults	YES	duals	YES	duals
C08	Adult BMI Assessment	YES	duals	YES	duals
C13	Osteoporosis Management in Women Who Had a Fracture	NO		NO	
C14	Comprehensive Diabetes Care Eye Exam Retinal Performed	YES	duals	YES	duals
C15	Comprehensive Diabetes Care Medical Attention for Nephropathy	YES	duals	YES	duals
C16	Comprehensive Diabetes Care HbA1c control	NO		NO	
C17	Comprehensive Diabetes Care LDLC control	YES	duals	YES	duals
C19	Rheumatoid Arthritis Management	NO		YES	duals
D09	High Risk Medication	YES	non-duals	YES	non-duals
D11	Part D Medication Adherence for Oral Diabetes Medication	YES	duals	YES	duals
D12	Part D Medication Adherence for Hypertension	YES	duals	YES	duals
D13	Part D Medication Adherence for Cholestrol Statins	YES	duals	YES	duals
		Duals higher 10/16		**Duals higher 11/16**	

Particular Observations:

- **NOTE:** *Our analysis of the relative comparison of duals/non-duals performance within MCS Advantage Inc should not undermine the evident lower level of compliance of the dual sub-group in the national context. We understand that intra-plan and intra-PR progress has been achieved with the duals, but significant extra effort and resources are still needed to reach appropriate levels of quality performance.*
- D-SNP duals have significantly higher STAR ratings than non-duals within the MCS Advantage beneficiaries.
- The following are key group characteristics that influence these results:
    - Duals have $0 copay in core benefits like physician visits and all prescription drugs (generics, brands and specialty).
    - The non-dual beneficiaries evaluated are in plans with $[redacted] -$[redacted] copays in brands and a [redacted]% coinsurance for specialty. They also have copays in core medical benefits like physician visits, laboratories, x-rays and others, compared to $0 copays for the dual beneficiaries.
    - For all dual plans there is a stricter coordinated care model that requires visits to the PCP and referrals for some specialty services.
- This result should be evaluated as a measure within MCS Advantage Inc. As CMS evaluates national policies for the STAR rating program, we understand our case is also consistent with the conclusion that there is an extra challenge in the improvement of quality performance for low income populations.
    - The non-dual population in Puerto Rico has a mix of low income and high out of pocket costs to access MAPD benefits that effectively lower disposable income to levels equivalent to a dual population, but without the added benefits.
    - The non-dual population in MCS Advantage Inc is not a similar representation of the non-dual population in plans of other US jurisdictions in relation to the duals.

(2) Comparison of performance of non-duals vs EGWPs

		All Beneficiaries		Diabetics Only	
Measure	Measure name	Significant Difference?	More odds to comply	Significant Difference?	More odds to comply
C01*	Breast Cancer screening	NO		NO	
C01	Colorectal cancer Screening	NO		NO	
C02	Cholesterol Management for Patients With Cardiovascular Conditions	NO		NO	
C03	Comprehensive Diabetes Care	YES	EGWP	YES	EGWP
C05*	Glaucoma Screening in Older Adults	YES	EGWP	YES	EGWP
C08	Adult BMI Assessment	YES	non-duals	YES	non-duals
C13	Osteoporosis Management in Women Who Had a Fracture	NO		NO	
C14	Comprehensive Diabetes Care Eye Exam Retinal Performed	YES	EGWP	YES	EGWP
C15	Comprehensive Diabetes Care Medical Attention for Nephropathy	YES	EGWP	YES	EGWP
C16	Comprehensive Diabetes Care HbA1c control	NO		YES	non-duals
C17	Comprehensive Diabetes Care LDLC control	YES	non-duals	YES	non-duals
C19	Rheumatoid Arthritis Management	NO		NO	
D09	High Risk Medication	YES	non-duals	NO	
D11	Part D Medication Adherence for Oral Diabetes Medication	YES	EGWP	YES	EGWP
D12	Part D Medication Adherence for Hypertension	YES	EGWP	YES	EGWP
D13	Part D Medication Adherence for Cholestrol Statins	YES	EGWP	YES	EGWP
		EGWPs higher 7/16		EGWPs higher 7/16	

Particular Observations:

- In general, there is a tendency of EGWP beneficiaries to have higher quality performance compared to non-dual beneficiaries in MCS Advantage Inc.

- These two groups in MCS Advantage Inc are in plans that are more comparable in terms of the delivery model and use of the PCP, as compared to the dual D-SNPs.

- EGWP beneficiaries at MCS are 98% + retirees of:

[redacted]

- The EGWP population of MCS Advantage Inc is composed of a concentrated group of beneficiaries that get retirement income along with Social Security income. This group also represents a concentration of beneficiaries that are more educated compared to duals and non-duals.

(3) Comparison of performance of Duals vs EGWPs

		All Beneficiaries		Diabetics Only	
Measure	**Measure name**	**Significant Difference?**	**More odds to comply**	**Significant Difference?**	**More odds to comply**
C01*	Breast Cancer screening	YES	duals	YES	duals
C01	Colorectal cancer Screening	YES	duals	YES	duals
C02	Cholesterol Management for Patients With Cardiovascular Conditions	NO		NO	
C03	Comprehensive Diabetes Care	YES	EGWP	YES	EGWP
C05*	Glaucoma Screening in Older Adults	NO		NO	
C08	Adult BMI Assessment	YES	duals	YES	duals
C13	Osteoporosis Management in Women Who Had a Fracture	NO		NO	
C14	Comprehensive Diabetes Care Eye Exam Retinal Performed	YES	EGWP	YES	EGWP
C15	Comprehensive Diabetes Care Medical Attention for Nephropathy	YES	duals	YES	duals
C16	Comprehensive Diabetes Care HbA1c control	YES	duals	YES	duals
C17	Comprehensive Diabetes Care LDLC control	YES	duals	YES	duals
C19	Rheumatoid Arthritis Management	NO		YES	duals
D09	High Risk Medication	YES	EGWP	YES	EGWP
D11	Part D Medication Adherence for Oral Diabetes Medication	YES	duals	YES	duals
D12	Part D Medication Adherence for Hypertension	NO		NO	
D13	Part D Medication Adherence for Cholestrol Statins	YES	duals	YES	duals
		Duals higher 8/16		**Duals higher 9/16**	

Particular Observations:

- The dual vs EGWP comparison reflects a tendency of the dual D-SNP population in MCS Advantage Inc to have higher quality ratings than the EGWPs.

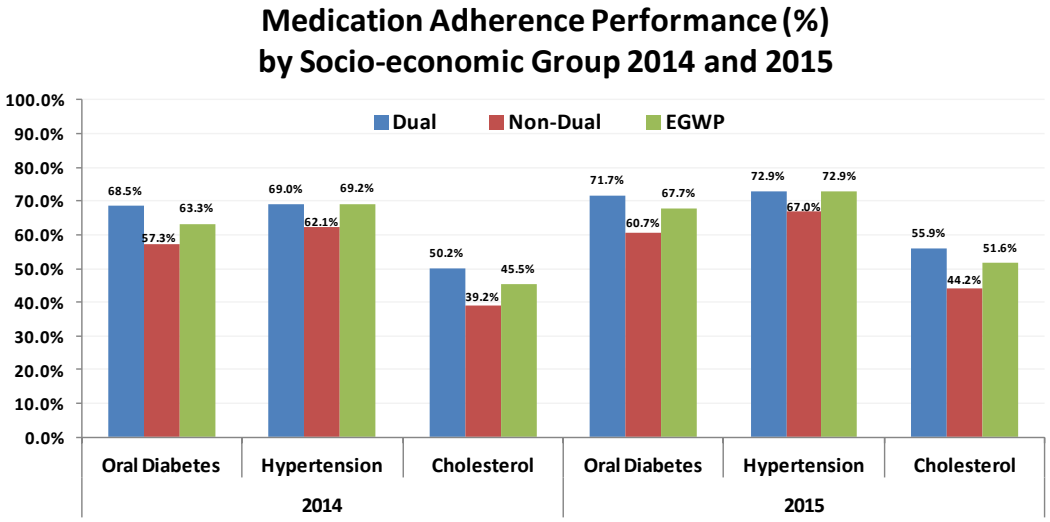
- The main differences of these two groups within MCS Advantage are:

    - Even when EGWPs get the employer contribution and have more benefits than the regular non-dual, they still have higher copays for prescription drugs and some core benefits when compared to the $0 copay dual D-SNPs.

    - The dual D-SNP Medicare Platino program in Puerto Rico has implemented additional efforts and investments related to individual care plans, mandatory PCP coordination and referrals, and economic incentives.

- These results should not undermine the urgent situation of the MA program in Puerto Rico. Our dual quality ratings are relatively higher because of an extra effort in trying to do more with less. HOWEVER, our performance results are still lower when compared to the national averages, especially on the medication adherence measures.

V. Special Note: Medication Adherence Performance by Category



As observed in the chart above, medication adherence performance within MCS Advantage Inc is a good reflection of how the lack of part D LIS and the higher OOPCs are impacting the non-dual population in Puerto Rico. This segment is effectively representing a sub-group of the poorest population with regards to the mix between low income and higher costs to the beneficiary. Supporting factors for the higher results in duals are mainly $0 copays and stricter care coordination, while for EGWPs the main factors include higher incomes, higher education and employer contribution support.

VI. Special Note: Members who leave the Plan

Table 1.1

Rates of Voluntary Disenrollment		Significantly Different from National Average?
Your Contract (H5577)	National Average	
18%	12%	Higher

The table also shows the national average rate of voluntary disenrollment and whether the difference between your contract's rate of voluntary disenrollment and the national average rate of disenrollment was statistically ($p < 0.05$) and practically (at least one percentage point difference) significant.

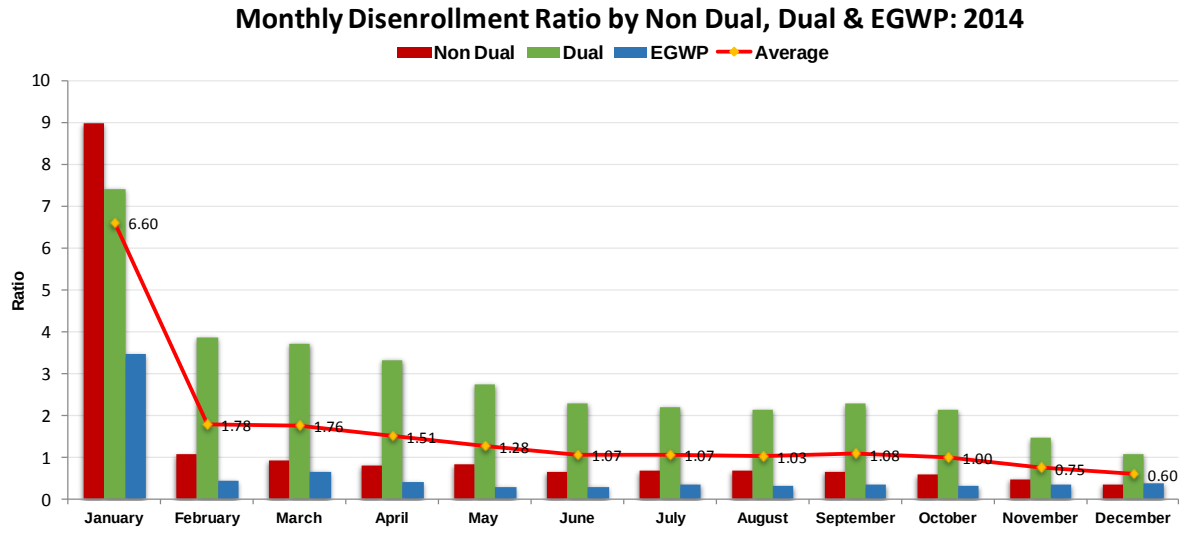
The table also shows the national average rate of voluntary disenrollment and whether your contract's rate of voluntary disenrollment was significantly different from the national average rate of disenrollment.

The illustration above is directly copied from the report of disenrollment survey from October 2014 sent to MCS by CMS contractors. The table is probably the most clear and strong evidence that we can present to establish the need for a special adjustment of the related STARs measure for plans that have a higher proportion of dual eligible members. As of October 2014, 44% of the MCS Advantage Inc members are

dual eligible, while in Puerto Rico duals are 49% of all MA beneficiaries. In contrast, the national average of the dual population is only 11%.

Duals have a statutory right to change MA plans every month. In a competitive market, this will inevitably mean that enrollment and disenrollment activity will continue throughout the year. Contrastingly, the non-dual population is subject to the strict rules of the Annual Election Period, and in general can only elect to change plans for October 15th to December 7th for the January 1st effective date. The chart below illustrates the scenario in the case of MCS Advantage Inc., where it is evident that the regulatory difference creates a change in behavior.

The comparison of the aggregate disenrollment ratios by H number does not produce a fair relative performance measure unless the methodology adjusts for significant differences in dual eligible membership. CMS should exclude D-SNP plans from the current measure or design an adjustment factor based on the proportion (%) of duals in a contract to avoid unintended and unfair negative outcomes for contracts that serve a high proportion of duals.



VII. Special Efforts Implemented by MCS Advantage Inc to Increase Quality

As explained in **Appendix 1**, the significantly lower cost-sharing amounts for the duals in Puerto Rico are a primary factor affective performance results. In addition, relative higher results for duals may also be supported by the delivery model platform evolving from Medicaid managed care. The fully integrated Medicare Platino program in Puerto Rico has been operating since 2006 and evolved from a mandated Medicaid managed care system that began in 1990s.

In addition, MCS Advantage Inc has been proactive in implementing special initiatives and investments for quality improvement across quality measures. Below we briefly describe some of the special initiatives implemented.

(1) Medication Adherence Reminders - Calls Campaign

MCS has been proactively encouraging the behavior of the adherence-eligible members with the help of [redacted], a local vendor designated to call a selected population of the aforementioned members. Through this campaign, MCS has been able to reach approximately 10,000 members per month. The purpose of the calls is to remind members of visiting their PCP, and to get their prescription for the specific medication(s) that they needed filled immediately. The emphasis is on those members who had a PDC (proportion of days covered) between [redacted]% and [redacted]%, and mostly [redacted] prescription below the target or barely above it.

During the period March –July 2014 we identified 21,967 unique members to assign on a rotating basis to [redacted] in order to call them:

Segment	Total members impacted	Members in at least 1 Adherence Measure as of 7/31/2014	% of members impacted
Duals	9,098	47,823	19%
Non-duals	8,728	41,791	21%
EGWP	4,141	19,349	21%
Grand Total	**21,967**	**108,963**	**20%**

In general, these were the results, in terms of prescriptions picked up at the pharmacy for those members whom [redacted] was able to successfully complete the call:

Month	LOB	Category	Called	COMPLETED	% COMPLETED	Picked up Rx	Call-to-Action %
MONTHLY AVERAGE	EGWP	OD	190	113	58%	88	71%
		RAS	897	510	54%	407	79%
		STATINS	410	221	55%	154	71%
	No Platino	OD	414	235	55%	179	71%
		RAS	1,860	1,069	53%	799	72%
		STATINS	877	475	53%	295	63%
	Platino	OD	533	283	52%	231	79%
		RAS	1,896	1,011	49%	796	77%
		STATINS	820	403	49%	260	65%

Even when the patient profiles were similar, the beneficiaries that filled their prescription after the contact was 74% for duals and for EGWP, while for non-duals the percentage was a lower 69%. This was the response considering the prescriptions filled within 14 calendar days of the contact.

(2) Primary Care Physician Incentive Program

In addition to the capitated PMPM compensation that the PCPs receive, MCS implemented an additional incentive program for PCPs based on the calculated STAR rating performance for their patient panel. In line with the philosophy of progressive improvement, incentive thresholds are usually established based on the current level of performance for all PCPs and the potential to move to the next level. Accordingly, the incentive is usually granted for achieving [redacted] for the Part C selected measures and [redacted] for the Part D selected measures.

Socio-economic Group	In at least 1 Adherence Measure?	Total	members with at least 1 adherence measure as of 12/31/2013	% of members impacted by PCP Incentive Program
Dual	Yes	36,059	36,705	98%
	No	17,820		
Dual Total		53,879		
Non Dual	Yes	23,605	32,206	73%
	No	14,315		
Non Dual Total		37,920		
EGWP	Yes	5,451	16,454	33%
	No	1,837		
EGWP Total		7,288		
Grand Total		99,087		
		65,115	85,365	76%

PCP Incentive Program impacted 76% of all members with at least 1 adherence measure as of 12/31/2013

In general, the PCP STARs incentive program at MCS monitors between [redacted] Part C and D measures, always including the [redacted] adherence measures and as well as the high risk medication. The incentive pays a maximum of $[redacted]pmpm distributed among the applicable measures and paid on a quarterly basis. If the PCP panel complies with a measure, the payment is applied based on 100% of his patients.

As illustrated in the table above, this MCS Advantage Inc incentive program has impacted a larger proportion of dual eligible beneficiaries relative to non-dual and EGWP. The EGWP beneficiaries are the least impacted by STARs / quality incentives to PCPs, in accordance with trends of PCP utilization and delivery model definition for each category.

(3) PAM (Medication Adherence Program)

The purpose of this program is to provide an additional service to beneficiaries at the community pharmacy level, focused on improving adherence to treatment. Beneficiaries receive an orientation about the importance of complying with their medication therapy, identify barriers to adherence, and to offer alternatives to improve adherence. This program is developed together with the community pharmacies that want to participate in the initiative and it targets members who fall into [redacted] adherence measures and have a PDC Rate between [redacted]% and [redacted]% in at least one of the measures.

The program started in April 2014 and the main activities undergone by the community pharmacies are: orientation about the importance of adhering to medication therapy, revision of members' medications, telephone reminders to pick up medications, and coordination of pick up dates.

So far, the PAM initiative has impacted 8,268 members who, as of August 31, 2014 have the following classifications for the adherence measures they fall in:

	Overall Status						
LOB	**Compliant**	**New Suspect**	**Not Compliant**	**Partially Compliant**	**Grand Total**	**Members in at least 1 adherence measure as of 8/31/2014**	**% of Impacted members**
Dual	1,475	610	963	997	4,045	50,859	8%
Non-Dual	851	200	986	954	2,991	43,369	9%
EGWP	368	62	368	434	1,232	19,947	20%
Grand Total	**2,694**	**872**	**2,317**	**2,385**	**8,268**	**114,175**	**4%**

Definition of status:

1. Compliant – The member has a PDC Rate of 80% or more in all adherence measures
2. New Suspect – The member has picked up only one prescription of the medication but is being assigned to the initiative in order to remind him/her to pick up the prescription and avoid having non-covered days for their medication
3. Not Compliant – The member has a PDC Rate less that 80% in all the adherence measures
4. Partially compliant – The member is not compliant in at least one measure

Proposal to the Center for Innovation, Presented by MCS Advantage in August 2013

In August 2013, MCS Advantage submitted a formal proposal to the CMS Center for Innovation for the program named "Medication Adherence Community Partners" or MACOP. Said proposal defined an integrated approach to medication adherence by enhancing with multi-stakeholder communications with the support of information technology and aligned incentives for pharmacies.

Unfortunately, the CMMI did not evaluate our proposal [redacted]. For the proposal, formal agreements and participation was structured between MCS, the University of Puerto Rico-School of Public Health, the Community Pharmacies Association and ASES, the local government agency administering Medicaid in PR.

The PAM described above is a pilot version of the MACOP project that MCS Advantage Inc decided to implement regardless of the unfavorable result with the CMMI evaluation process. We welcome any additional input from the CMMI with regards to this proposal.

VIII. Main Conclusions and Recommendations

MCS Advantage, Inc. (MCS) is committed to the continuous improvement of the quality of services provided to approximately 180,000 MA beneficiaries currently served by MCS in Puerto Rico. The detailed data and analysis reviewed for our population reflect two main realities:

(1) Socio-economic status impacts the performance of plans in the STARs quality system, with a tendency of lower ratings for the plans with a higher proportion of duals and low income beneficiaries.

(2) Puerto Rico has distinct benefit disparities established by law, which lowers incomes and increases out of pocket costs (OOPCs) for the non-dual population in the island.

- **a.** The lack of Part D LIS, along with other aggravating factors, is evidently a barrier to quality improvement in Puerto Rico.
- **b.** The compounding results include the fact that 0% of the plans in PR reached 3.5 STARs in 2014 and 0% reached 4.0 STARs in 2015.
- **c.** Not reaching levels of higher MA rebates and the 5% quality bonus is effectively aggravating and perpetuating the disparities as plans have less money to lower cost-sharing levels for future years.

We recommend to CMS the implementation of short term adjustments to address these two factors and avoid unintended harm and disparities for plans serving a high proportion of low income citizens. Making the appropriate and substantiated adjustments will provide more equity and balance to the STAR rating program across the nation, including the Territories.

Recommendations of Policy Adjustments Needed in the Short Term

1. Assure the **integrity, balance and objectivity** of the STARs program in the Territories and account for statutory benefit disparities by:

- **a.** Excluding medication adherence measures for Territories (No LIS) from the part D and overall plan rating calculation, until the benefit disparity is eliminated; or
- **b.** Including medication adherence measures only within the improvement measure, but not the separate adherence measures to avoid the disproportionate impact of the benefit disparity; or
    - This would effectively maintain a measurement of medication adherence for territories that could be positive or negative depending on plan performance. It presents an option to measure improvement in adherence without applying the stand alone adherence measures that are influenced by benefit disparities across jurisdictions.
- **c.** Calculating medication adherence thresholds for NON-LIS areas separately.
    - CMS calculates separate thresholds for all PDP plans and all MAPD plans. We understand the MAPD-NON-LIS category is legitimately different from the regular MAPD in order to have a separate threshold calculation.

2. Include a socio-demographic adjustment to account for the extra effort needed to reach higher levels of performance within low income populations.

3. Unless it is addressed by a more comprehensive socio-demographic adjustment, there should be a particular adjustment for the measure "members who leave the plan" in the case of contracts with high proportion of dual eligible who are allowed to change every month.

- The right to change plans every month for duals is naturally a significantly distinct rule from the regular lock in period for non-duals.
- The dual proportion of 11% at the national level is too distant from the 49% dual proportion in Puerto Rico for plans to be evaluated under the same thresholds with no adjustment. Contracts and markets with 25% or more proportion of duals will naturally exhibit a different rate of plan changes than plans or markets where the dual proportion is closer to the 11% average.

4. For Non-Dual, Non-EWGPs, MAPDs, LIS eligible membership, allow for the definition of a an LIS version of MAPD products which considers enhancements to pharmacy cost-sharing as part of the regular Medicare benefit and not as supplemental benefit subject to MA rebate retention by CMS.

- For LIS eligible individuals, MAPD plans do not have to allocate MA rebate dollars for the coverage of the LIS level benefits. Under this recommendation, CMS would develop a special bid methodology where plans in NON-LIS areas would be able to cover LIS level benefits as a mandatory Medicare benefit not subject to the CMS retention applicable when paying supplemental benefits with MA rebate dollars.

5. For the purposes of the MA revenue impact, apply all these changes **starting 2016 payment year** to avoid impact to beneficiary in 2016, even if the 2015 STAR ratings are already public for other purposes.

- The June bid cycle for 2016 bids still allows CMS to define the policies for revenue components. Any financial implication of legitimate policy decisions made based on all the analysis done through this RFI should not be delayed as a matter of policy and beneficiary protection.

- Not implementing the 2016 impact by recalculating 2015 performance just for said purpose may result in lower benefits and higher OOPCs that would not occur under the new policies.