Submitted via email to PartCandDStarRatings @cms.hhs.gov

November 3, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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:

UCare would like to take this opportunity to thank CMS for recognizing the importance of support for high quality plans through the Star Ratings program and for seeking comment and data on the differences in plan performance between dual eligible and non-dual eligible members based on quality measures defined in the Star Ratings program. Our document and attachments outline the comparison of our dual eligible product with our Medicare Advantage product.

UCare is an independent, nonprofit health plan serving over 110,000 Medicare Advantage members in Minnesota and western Wisconsin. *UCare for Seniors*, our Medicare Advantage-Part D (MA-PD) plans, contracts H2459 and H4270, earned 4.5 stars in the 2015 Medicare Star Ratings. Minnesota Senior Health Options (MSHO), contract H2456, our fully integrated dual eligible Special Needs Plan (FIDE SNP) for those age 65 and older, earned 3.5 stars for 2015.

UCare has offered MA-PD plans since 1998. Enrollment for MA-PD plans started in select Minnesota counties and then expanded state-wide, with a separate contract developed for Wisconsin in 2009. Total membership for these MA-PD plans exceeds 110,000.

Since 1997, we have partnered with the state Medicaid agency to offer the MSHO plan. The MSHO program began as a dual demonstration, and UCare was one of the first plans to offer this product. In 2006, MSHO became a dual Special Needs Plan (D-SNP) after Congress authorized Special Needs Plans. Today, MSHO is known as one of a handful of "legacy" SNPs, well known by CMS for its longevity and benefit to frail elderly dually eligible Minnesotans.

With eight plans offering MSHO in our state, UCare has the largest market share of enrollment, with 9,753 members as of December 2013. Our MSHO plan has particular factors to take into consideration, such as:

- 25% of our members are age 85 or older.
- 23% of our members age 85 or older reside in an institutional setting.

- 58% of our members have between two and six chronic conditions and 31% have seven or more.
- 28% of our members have dementia disorders, compared to only 5% in the MA-PD population.
- 11% of our members have Alzheimer's disease, compared to 3% in the MA-PD population.

Overview of Statistical Analysis

UCare is in a unique position to offer insight on the differences between MA-PD Star ratings and those of D-SNPs. Our contracts for these plans are separate, which allows us to easily identify and statistically evaluate differences in performance between dual eligibles and non-dual eligibles as these populations are largely divided between our two products. While our comparison is not able to control for differences in benefit design (such as cost sharing) between the plans, we are able to control for other important differences. Both of our plans are offered in the same markets and under the same care systems. And, as shown below, we are able to break out some of the results by care system in order to control for possible differences at the provider level. We do have some dual eligible enrollment in our MA-PD plan and were able to break out performance results for that plan by dual and non-dual populations for some of the measures.

Overall, statistically significant (and in some cases, large) differences were observed in a preponderance of measures we examined. Most notably, performance differs in medication adherence rates, demonstrating that factors, such as the sociodemographic status of the population, impacted the outcome.

As expected, we also identified some measures where the results are the same or better for our MSHO population, such as diabetes care. This can be attributed to the Model of Care required for D-SNPs. A primary distinguishing characteristic for MSHO is the assignment of a care coordinator. The primary responsibility of the care coordinator is to conduct a face-to-face assessment to identify health and social needs, gaps in care, and then work with the member to establish a plan of care. The care coordinator arranges services to fill identified gaps in care and serves as the coordinator with the member's primary care provider, transitions of care, and is the main point of contact with UCare.

However, when we break out results for our MA-PD by dual eligible and Medicare-only populations, we also see that duals underperform relative to our Medicare-only population in that plan. For most measures, our Medicare-only population in the MA-PD plan performs better when compared to dual eligibles in the MA-PD and dual eligibles in our D-SNP.

Please note: We fully support the findings in Inovalon's *An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures* study (October 2014), demonstrating that sociodemographic status obstacles "results in greater quality performance gaps, signaling the opportunity to potentially adjust Star ratings and leverage data-driven comparisons of quality across Medicare Advantage plans."

Additional Comments on Star Ratings Measures

UCare reviewed the measures contained within the Star Ratings program for appropriateness in its application to a dual eligible population. Overall, we believe the majority of Star Ratings program measures are clinically relevant to the MA-PD and D-SNP populations, with a few exceptions cited later in this response. However, in general, the measurement specifications do not adequately account for the unique clinical characteristics of a D-SNP population and how the prevalence of those clinical characteristics impacts the overall performance. We believe that contraindications to therapy are not adequately accounted for in the measurement criteria. This is especially true for the D-SNP population who, given the clinical demographic of the population, have a higher incidence of these contraindications.

There are four broad categories of the Star Ratings program measures that we believe indicate contraindications for the D-SNP population:

I. Preventive Screenings
II. Patient Safety measures
III. HOS
IV. CAHPS

The types of measures included in the program as well as potential factors impacting outcomes are described below.

I. Preventive Screenings**:** All UCare members deserve the highest quality of culturally competent care. Our work plan efforts to improve care include double the efforts and resources for our MSHO product, but don't necessarily reflect higher performance. While our persistent efforts have resulted in performance improvement, we have been unable to improve performance to the 4 Star performance threshold for preventive screenings. There is a significant performance gap between our MA-PD and MSHO plans, even with these significant and sustained performance efforts.

Performance rates, and the resulting Star Ratings assignments, for Preventive Screenings have statistically performed at a significantly lower rate for MSHO. For instance, program measures such as Breast Cancer Screenings and Colorectal Cancer Screenings have resulted in lower ratings in D-SNP versus MA-PD only populations.

We believe there are a number of factors contributing to the lower performance in the dual eligible population in relation to the Preventive Screenings. Our data analysis indicates that the lower ratings are primarily attributed to sociodemographic status. We also believe that other clinical factors are at play as described below:

- Approximately twice as many MSHO members have been identified with a "Frailty Flag" in comparison to MA-PD members.
- MSHO members have a higher frequency of having multiple chronic diseases than the MA population.
- Approximately twice as many MSHO members have an ongoing diagnosis of depression when compared to the MA-PD population. Depression is often a comorbid condition

with a chronic disease. The presence of depression has been shown to impact the member's ability to manage conditions effectively.

UCare commits significant resources to assist with D-SNP health improvement efforts. These additional resources and efforts include providing a mobile mammography van in communities for members with access difficulties, offering breast cancer and colorectal cancer screening incentives, and providing education about colorectal cancer screening options.

We offer these additional resources, for instance, because in traditional Hmong culture, preventive care is not common. Based on feedback from new immigrant members, we created a specific outreach program to educate and establish trust with our female MSHO Hmong and Lao members regarding the importance of mammographies. Last year, a clinical liaison made home visits, showed a video and answered questions/explained the importance of mammography. She then scheduled appointments either to a designated facility or to a mobile mammography van. Calls were made to members the night before, letting them know when their ride (if needed) would arrive the next day. The clinical liaison traveled with the members. She also ensured that interpreters were available during the mammogram visits.

Last year, 130 Hmong (and five Laotian) MSHO members received mammograms. Now that trust is established, these members are no longer afraid of this preventive service and are making annual appointments with the help of their individual care coordinator – leaving UCare's clinical liaison free to work with a new group of members.

And yet, even with work such as this, we continue to see a significant performance gap between our MA-PD and MSHO plans.

II. Patient Safety Measures: We believe there are a number of factors within the measurement specifications that contribute to the differences in outcomes. Here are some examples:

- Patient Safety measures are exclusively measured using only prescription drug data. "Diseases" are "inferred" based on the types of medications a member is taking versus an actual medical diagnosis. For example, therapy for atrial fibrillation may include a beta blocker for heart rate control. In this case, the PDE data categorizes these members as having hypertension and erroneously includes them in the denominator. Due to the number of conditions impacting our dual eligible population, we believe that there are a higher proportion of dual eligible members misidentified and inappropriately included in the denominator.

- Further, the Patient Safety measures do not have any upper age limits. Part C measures for diabetes, cholesterol screening/control, and hypertension all have upper age limits. Because our MSHO members are older (25% are over age 85) and have a more complicated constellation of conditions, we believe there is a stronger likelihood of members having contraindications to therapy. While we appreciate CMS' efforts to account for specific clinical circumstances (e.g., adjusting for ESRD, IP and Hospice stays), there are additional considerations that need to be included.

- In addition to overall product results showing the discrepancy between the products, the discrepancy is further evidenced when we break out the medication adherence results by provider. We believe this further supports our contention that there are clinical contraindications for care. By looking at members in the same product, using the same provider, there does not appear to be any other reason than a clinical contraindication for adherence to the measure. The rates between the two products show statistical significance that is different for all measures.

III. HOS: We believe that the self-reported nature of the measures does not accurately reflect performance. A significant percentage of our MSHO population (28%) have dementia disorders and may not be able to accurately reflect the services performed in the last six months, much less self-report at all.

It is not realistic to expect MSHO members to self-report that their physical and/or mental health has maintained or improved over a two year period when they have a high incidence of chronic diseases and are considered "frail elderly." In fact, this contradicts the natural and expected progression of chronic diseases. This measure should exclude the frail elderly population.

Then too, the wording of the questions biases the results. The maintaining or improving physical health question lists activities such as moving a table, pushing a vacuum cleaner, bowling, playing golf and climbing several flights of stairs. With our MSHO population significantly older, lower income and perhaps struggling with racial disparities, the responses to these types of questions may be rated lower due to irrelevancy.

IV. CAHPS: Additionally, the MSHO population is over surveyed. These members receive a CAHPS survey from the plan and one from our Medicaid agency. The result is lower response rates and a larger variance in the responses.

Recommendations

The documentation demonstrates that there are real and statistically valid differences shown when comparing D-SNP populations with MA-PD plan populations. We suggest that CMS work with D-SNPs in the following manner:

1. For payment years 2016 and 2017, modify the quality bonus payment criteria for D-SNPs to provide the quality bonus for D-SNPs that achieve a 3.5 Star rating level. Our analyses demonstrate that differences for dual eligibles are keeping otherwise high-performing plans like MSHO out of 4 star status. This provides CMS time over the next two years to create modifications to the measures to build a model that most appropriately values the work UCare and other plans provide to dual eligible members. Making a temporary adjustment for 3.5 Star plans is targeted and keeps the actual results clear for public and quality improvement reporting.

2. Consider adjustments to Star measures such as:

HEDIS Data: While there is no question that preventive screenings are important aspects of care, preventive screenings should not be applied to the D-SNP population until such time that performance can be adequately case-mix adjusted. The inclusion of these measures in the Star Ratings program does not yet adequately take into account the unique challenges faced by the dual eligible population and the barriers they have in seeking these services.

PDE Data: Although we appreciate efforts to adjust for ESRD and Hospice status, we do not believe these measures are adequately case-mix adjusted to account for the population demographics of the dual eligible population.

Patient Reported Data (CAHPS/HOS-Based Measures): We believe these measures reflect important aspects of patient care and satisfaction, and we appreciate that CMS has adjusted for case-mix when reporting results for these measures. However, the inclusion of members with dementia negatively impacts performance and inhibits our ability for accurate feedback in these important aspects of care. We believe that members with dementia should be excluded from "patient reported" measures.

3. Work with the D-SNPs to design and implement a pilot program that tests more substantial modifications to performance measures as well as interventions to reduce disparities as deemed appropriate.

We look forward to continued conversations with CMS on this important issue. Please contact me at 612-676-3634 should you have any questions.

Sincerely,

Ghita Worcester, Senior Vice President
Public Affairs and Marketing

Attachments: Stars Analysis MSHO vs. Medicare Advantage
CAHPS and HOS