November 3, 2014

Sean Cavanaugh
Deputy Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted to: 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 Deputy Administrator Cavanaugh:

Cigna-HealthSpring welcomes the opportunity to offer comments on the impact of dual-eligibles on Star ratings in response to the Request for Information (RFI) regarding "Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees". We appreciate CMS' efforts on behalf of dual-eligible beneficiaries, providers, and health plans to improve quality measurement and advance better health care delivery and better health for the nation. Our response provides data that demonstrates the difference in Star measurements for dual-eligible members vs. others on several key Star metrics. Our experience, together with a growing body of evidence from researchers, health care providers, and others, clearly shows that plans that serve a disproportionate share of dual-eligible members are at a significant disadvantage with regard to achieving higher Star ratings and resulting bonuses. Moreover, these results illustrate the need for action to stop the shift of resources away from dual-eligibles, Medicare's most vulnerable population.

Cigna-HealthSpring, a Cigna company, is one of the leading health plans in the United States focused on caring for the senior population predominantly through our Medicare Advantage (MA) plans, and through other Medicare and Medicaid offerings. Our focus on this market has allowed us to develop a unique approach to health care coverage for beneficiaries. We have a deep understanding of the needs and challenges facing both patients and physicians, and thus have developed a collaborative model that provides more access to high quality preventive care for our customers while supplying physicians with the resources they need to deliver that care. Specifically, Cigna-HealthSpring recognizes and rewards physicians for quality over quantity of care, and we provide extra nurse and technology resources so physicians can devote more time and attention to their patients. The result: healthier, more satisfied customers with lower medical costs.

Over 30 percent of Cigna-HealthSpring's MA members currently are dually eligible for both Medicare and Medicaid benefits and services, compared with about 18 percent of the MA population overall. While the majority of our dual members (66 percent) are enrolled in special needs plans (SNPs) specifically designed to address their needs and that assist members with accessing and coordinating benefits across programs, a significant number of dual-eligible members choose to enroll in our regular MA offerings.

Dual-eligible beneficiaries, out of all our beneficiaries, derive the greatest benefit in terms of quality health outcomes – and improved quality of life – from the coordinated care that our MA plans provide. We strongly urge CMS to consider changes to the Stars rating system that will support the continued provision of these critical services to this vulnerable MA population.

Our decades of work on behalf of Medicare beneficiaries has shown that achieving high-quality health care and better outcomes is a team effort involving the health plan, providers, and patients. Our experience at Cigna-HealthSpring clearly demonstrates that dual- eligible beneficiaries have a more difficult time achieving desired quality health outcomes, such as screenings and preventive services, adhering to prescribed medication regimens, or following through with basic treatment recommendations. Sociodemographic factors, such as language barriers, nutrition, and housing, play a key role in keeping some members from achieving better outcomes, despite having access to the same providers, services, and benefits as all members. For example, low-income members may not follow through on recommended screenings or preventive care, or may have difficulty with medication adherence, because they lack access to transportation.

Our duals population requires tremendous investment in resources such as social workers, behavioral health specialists, nurse practitioners, in-clinic pharmacists, and other physician extenders to address the medical and social issues that often keep dual members from achieving the same health care goals and outcomes as other members. Ensuring that prescriptions are filled, medications are taken as prescribed, screening appointments are kept, and diagnostic tests are performed often means adding additional benefits such as transportation services, social workers, pharmacists, or advanced care nurses to supplement the traditional care teams that typically meet the needs of non-dual patients.

In the RFI, CMS asks for analysis of the difference in measurement scores between dual and non-dual (or LIS and non-LIS) enrollees in the same contract. CMS also requests analyses that use a multi-variate model, including control variables. An analysis that makes use of multi-variate modeling techniques is beyond the capacity of a single plan such as ours, given both time and data constraints, and is best conducted by an entity that can aggregate data from multiple MA plans in order to ensure a sufficient study population and meaningful results.

We understand that CMS has received such an analysis from Inovalon, a data analytics company that used plan data provided by multiple MA organizations, together with data owned by Inovalon. Further, we understand that Inovalon's analysis shows that dual-eligibles have significantly lower Stars scores on ten of 18 measures examined in the study, including six of eight current Star measures. These findings are consistent across sampling methods and statistical models, demonstrating the reliability of the findings. Measures where duals consistently perform significantly worse include breast cancer screening; drug-drug interactions; high-risk medications; medication adherence for hypertension; osteoporosis

management after fracture; use of spirometry testing for COPD; and all-cause readmissions. In addition, the Inovalon analysis finds that the share of a plan's membership that is dually eligible has a significant effect on Stars performance: plans serving a high proportion of dual members have a harder time achieving high-quality scores.

The Inovalon study looked at characteristics of dual-eligibles that help explain the observed differences in quality outcomes. The study found that duals are more likely to have chronic conditions that impact other health outcomes, like alcohol/drug/substance abuse, anxiety and bipolar/major depression. Duals comprise three-fourths of MA members with HIV and schizophrenia, more than eight out of ten members with inadequate/lack of housing, 86 percent of members with intellectual disability, and more than half of MA members using a wheelchair. All of these factors help to explain why duals may have a harder time following through with medication adherence, recommended screenings, or other services. As noted earlier, we devote significant resources to helping such members – social workers, on-site high-risk pharmacists, behavioral health case managers – but overcoming the confluence of social and economic challenges facing dual-eligibles is impossible.

The results of Inovalon's study provide compelling evidence of the impact that serving a large share of duals can have on Stars performance. The study addresses all of the elements included in the RFI, identifying differences in measurement scores between dual and non-dual enrollees in the same contract and plan, statistical testing to evaluate the significance of the differences between measurement scores between dual and non-dual enrollees in the same plan; and multi-variate modeling to isolate the effect of dual status, the share of plan enrollment represented by duals, and other potential explanatory factors for Stars performance.

Cigna-HealthSpring's own experience further supports Inovalon's findings. We examined 2013 performance differences for duals vs. non-dual members across 17 measures for each of our 14 contracts that were active in 2013. We chose measures for which we had population level data across contracts, and that reflects care inputs and health outcomes.

For the 2013 plan year we identified the members who were dually-eligible for Medicare and Medicaid for at least one month during the year, representing 1/3 of all Cigna- HealthSpring members during 2013. For each contract we measured the compliance rate, or "score" achieved by all duals for whom we had performance data and compared it to the compliance rate for all non-dual members with performance data in the same contract. For some contracts we did not have performance data for both duals and non-duals for all 17 measures; we report data on all available measures for each contract.

Looking across all contracts in 2013, we found that duals had lower compliance rates on nine of 17 measures (37 percent), while duals had better compliance rates than non-duals on six of 17 measures (21 percent); for two measures there was no difference in scores for the two groups. The measures where duals most often had lower compliance rates were High Risk Medications, Medication Adherence for Hypertension, Medication Adherence for Cholesterol, and Medication Adherence for Diabetes.

While the enterprise level analysis is interesting, a contract-level analysis offers a more appropriate comparison of Star ratings for duals and non-duals, since duals are not evenly distributed across all contracts. Additionally, providers, networks, and environmental conditions

are most consistent within a contract. (Comparisons at the plan benefit package level are not possible because of small numbers that make meaningful comparison of duals and non-duals impossible).

Like the enterprise level analysis, the measures where duals most consistently score below non-duals are High Risk Medications, where duals underperform in all 14 contracts, and duals underperform in most of the contracts of the three Medication Adherence measures – Medication Adherence for Hypertension, Medication Adherence for Cholesterol, and Medication Adherence for Diabetes. We note that each of these measures carries a weight of 3.0 in the Stars scoring methodology, making the impact of these scoring disparities even greater. Other measures on which duals are likely to underperform are COPD Exacerbation – Systemic Corticosteroids,Rheumatoid Arthritis Management, Antidepressant Medication Management, and Breast Cancer Screenings.

One area where duals often perform as well as or even better than non-duals is Access to Preventive and Ambulatory Care Services. The fact that duals perform better on Access to Preventive Care is notable, since it provides evidence that access issues are not contributing to duals' lower performance on clinical measures. Several of the contracts where duals perform as well as or better than non-duals in access may be due to the presence of Living Well Centers, which are Cigna-HealthSpring clinics that deliver care to those that are most vulnerable. Cigna-HealthSpring's commitment to duals is demonstrated by the fact that many of these clinics are situated in areas where there is a large concentration of dual-eligible members. Our Living Well Centers, like our performance on Access to Preventive Care measure, demonstrates Cigna-HealthSpring's commitment to providing the best possible access and care to duals, and highlights the fact that differences in Stars performance is not a reflection of our commitment, but point to the barriers duals face outside of the health care system.

Furthermore, we offer benefits and services designed to help patients access the care they need, and offer tools and incentives to encourage providers to deliver high-quality, high-value care as efficiently as possible. For example, many of our MA plans include transportation services to help low-income members or those in rural areas keep appointments. We have also invested in foreign language translation services for our members that do not speak English, and text telephone (tty) services for our members with hearing and speech impairments. Many of our members also have access to case managers, social workers, and high-risk pharmacists to assist patients in managing and coordinating their health care and social support needs.

In addition to data on the performance differences between dual and non-dual members, the RFI also requested "research that demonstrates that high quality performance in MA or Part D plans can be achieved in plans serving dual eligible beneficiaries and how that performance level is obtained." Cigna-HealthSpring has first-hand experience with high-quality performance in an MA plan that serves a large share of dual-eligible members. Contract H5410, known as the Leon Medical Centers Health Plans (LMCHP), has achieved an overall Stars rating of at least 4.5 for each of the last three years, despite having close to half of its membership dually-eligible.

How does LMCHP achieve high Star ratings for its dual members? This performance is the result of great effort and investment on behalf of the health plan and its providers, together with a highly integrated structure, long-term investment in services designed to reach dual-eligibles and other vulnerable populations, and a narrow geographic footprint that makes these investments cost-effective to implement and operate.

Leon Medical Centers (LMC), the health plan's exclusive provider of primary care services, operates seven large state of the art medical centers in Miami-Dade County, Florida. These facilities offer a wide array of services including primary care, specialty, diagnostic, therapy, lab, as well as many others. The plan and the providers devote immense amounts of resources to coordinating care for all its members but especially the dual population. This includes, but is not limited to, making appointments, providing relevant medical information in a coordinated manner and making multiple reminder calls. LMC has purchased some of the most sophisticated software currently available to serve this population and carry out that coordination. The health plan also provides unlimited transportation through its providers so that the members have access to the care they require. Almost 75 percent of the membership must be transported to and from each appointment. In addition, the health plan, in conjunction with LMC, has designed a pharmacy benefit which is considerably more comprehensive than the standard benefit and incentivizes members to use one pharmacy system which helps to avoid medication duplication and its consequences. These incentives include $0 copay, low unit drug cost and free prescription delivery to patients' homes. Finally, by serving a narrow geographic zone, LMCHP can overcome the challenges of a large dual population which is predominately non-English speaking.

Cigna-HealthSpring is proud of the LMCHP and its success in bringing excellent health care and improved health outcomes to a vulnerable population, and we look to that success for best practices and models for serving duals in our other markets. We also recognize, however, that many of the elements that make LMCHP so successful – the level of integration and centralized control and the geographic cohesion of its membership in particular – cannot simply be adopted in other markets. Therefore LMCHP is both a model for the kind of health outcomes we are striving for wherever we serve duals, and a caution against the premise that because one plan achieves superior outcomes for duals, all plans should be equally able to achieve such outcomes.

In conclusion, Cigna-HealthSpring appreciates the opportunity to provide data and insight into the issue of how serving dual eligible members impacts Star ratings in the MA and Part D program. Our data and experience illustrate the challenges MA plans face in serving dual members. We remain committed to providing these members with the benefits and services they need to achieve and maintain good health. We urge CMS to do its part to improve health outcomes for this vulnerable population by making appropriate changes to the Stars rating system to level the playing field for plans that serve a large share of dual-eligible beneficiaries.

Should you have any questions about the information included in our response, please contact Gary Bailey, Cigna-HealthSpring Government Affairs, at Gary.Bailey@Healthspring.com or (615) 403-3141.