To: The Center for Medicare & Medicaid Services (CMS)

From: Tom Betlach, Director AHCCCS

Sent via email 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

Arizona's Program Is Built on the D-SNP Model

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's single state Medicaid agency, provides health care coverage to the State's acute and long-term care Medicaid populations, including dual eligible members. Since 1982 when it became the first statewide Medicaid managed care system in the United States, AHCCCS has operated under a federal 1115 Research and Demonstration Waiver that allows for the operation of a total managed care model. Over the past eight years, AHCCCS has pursued strategies to better align service delivery by reducing fragmentation and increasing system alignment and integration. For the 137,000 dual eligible members enrolled in AHCCCS, Arizona has achieved this integration through the Medicare Dual Special Needs Plan model. AHCCCS requires all Medicaid contracted managed care organizations to also be Dual Eligible Special Needs Plans (D-SNPs). The D-SNP requirement offers dual beneficiaries the opportunity to align all Medicaid and Medicare service coordination through one health plan.

D-SNPs Should Be Recognized Not Penalized for Offering Higher Quality Care for Dual Eligible Members in Arizona

In Arizona, all D-SNPs must hold a state contract for Medicaid, which is awarded through a highly competitive bidding process. This allows only vested entities to enter the D-SNP marketplace. The specific Arizona counties and populations in which plans may enroll members are outlined in MIPPA agreements. These agreements hold plans accountable to AHCCCS for high standards of care coordination, quality performance and information sharing. By requiring D-SNPs to also hold Medicaid contracts, the State has not only increased plan accountability for quality performance, but also ensured a higher level of plan alignment — members with the same health plan for both Medicare and Medicaid. Arizona has over 44% (60,000 individuals) of all duals in an aligned plan, a rate higher than any other state in the nation.

AHCCCS supports findings in recent literature, such as the 2014 study by Inovalon and others,[1] suggesting that dual status causes lower MA and Part D quality measure scores. Additionally, in AHCCCS' own experience, the D-SNP model and plan alignment yield higher quality performance. A 2012 analysis of one of the AHCCCS health plans conducted by Avalere Health revealed that plan performed better than Medicare fee-for-services for dual eligible across several measures. Results demonstrated:

- 43% fewer days spent in the hospital (per 1,000 months of beneficiary enrollment);
- 31% fewer in-patient discharges (per 1,000 months of beneficiary enrollment);
- 19% lower average length of stay;
- 21% lower readmission rate;
- 9% fewer Emergency Department visits (per 1,000 months of beneficiary enrollment); and
- 3% higher proportion of members accessing preventive/ambulatory health services.[2]

AHCCCS encourages CMS to utilize these studies to make changes to the Star Rating system that support the D-SNP model, which has been a success in Arizona. Studies must contain adequate sample sizes and reliable validation that statistically significant differences exist between duals and non-duals for certain measures impacting the Star Rating system.

Arizona elected not to pursue a duals demonstration because of the success of the D-SNP model. The D-SNP model has given Arizona the ability to align incentives that drive health plan performance and support alignment efforts to better coordinate care for dual members. We applaud CMS's efforts to encourage all plans to deliver quality care to the vulnerable members they serve, but changes must be made to ensure equity throughout the system. Arizona's continued success depends on the ongoing viability of the D-SNP model. This includes members' ability to access supplemental benefits, such as dental, vision, and hearing that have a direct impact on the health of dual eligible members. Withholding plan payments based on inequitably applied Star Ratings serves only to limit or eliminate these important benefits.

Thank you for the opportunity to provide input. Arizona is hopeful that positive changes can be made in the future to address this disparity in the application of the Star Rating system.

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[1] See Bishop, Shawn: *Are MA Star Ratings Biased Against Plans Serving Disadvantaged Populations?* Health Policy Analysis, 2012; Inovalon Part 1: *Member Level Analyses, An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures*. October 2014; http://healthaffairs.org/blog/2014/09/22/medicare-advantage-stars-systems-disproportionate-impact-on-ma-plans-focusing-on-low-income-populations/; National Quality Forum Technical Report, Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors. August 15, 2014.;

[2] See Murugan, Vernee, et. al.: *Analysis of Care Coordination Outcomes: A Comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries*. Avalere Health, July 2012. http://www.azahcccs.gov/reporting/Downloads/Integration/AvalereHealthStudy_re_DualEligibles7_2012.pdf .