Contract ID: H5471

Contract Name: Simply Healthcare Holdings

Organization/Market Name: Simply Healthcare Plans, Inc. (The Plan)

Introduction

The Plan has been offering Medicare Advantage and Dual Special Needs Products to the South and Central Florida communities since January 1st, 2012. The Plan currently services around 29,000 lives as of October 2014. The Plan's initial STAR rating was a 3.0 for 2014 and subsequent STAR rating for 2015 was a 4.0 after constant improvement and continuous dedication to member education, disease prevention and management, and advocacy.

The Plan has observed several differences in performance between the beneficiaries enrolled in the Dual SNP plan versus the beneficiaries from the MA products. There are several challenges starting from the enrollment/disenrollment ability versus lock-in to compliance and response to interventions. In the following pages, we will demonstrate some of the differences that the Plan has been able to identify between the two populations above mentioned. All supporting data is available upon request.

Pharmacy Adherence

As with many of the differences observed between MA beneficiaries versus DSNP beneficiaries, the Plan routinely monitors all of the medication adherence measures as reported by CMS in the patient safety reports as published in the Acumen site. In the report published by CMS for DOS 01/2014 to 08/2014, we can clearly see the difference in performance from one population to the other. Such difference is greater in some measures than in others, but nevertheless, there is a significant difference observed.

In the above mentioned review period, the CMS published patient safety report identified a difference in performance for the Medication Adherence for Diabetes between the LIS and Non-LIS populations of 2% points. The lower performance is within those beneficiaries in the LIS demographics with 79% compared to the Non-LIS demographics with a reported rate of 81%. The same can be identified in the Statins performance with a difference of 3% points between the two populations and a reported rate of 74% for LIS beneficiaries versus a 77% for Non-LIS beneficiaries. The largest difference observed was on the RAS Antagonists Medication Adherence measure where the discrepancy between LIS and Non-LIS was observed to be 4% points with the LIS beneficiaries being at 79% while the Non-LIS beneficiaries were at 83%.

The concern the Plan has is not just based on the reported differences between one population and the other. The Plan's membership is mostly composed of DSNP beneficiaries that all have

some sort of LIS status. When reviewing the data for the same period, it is identified that the smallest difference in member years in any of the three measures was 639 in the Diabetes measure while the largest difference was 1630 member years in the RAS Antagonists measure. Taking this into consideration, the Plan's overall performance is negatively affected by the DSNP beneficiaries who represent the largest volume of beneficiaries enrolled in the Plan.

Readmission Rates

While the Plan pays close attention to both Dual SNP and MA beneficiaries and continuous to monitor every one that is discharged alive from an acute setting, the Plan has identified that an additional disadvantage is proven for those Plans with higher enrollment of DSNP beneficiaries. The difference is based on the fact that DSNP beneficiaries participating in SNP programs within Medicare Advantage organizations have a significantly higher rate of enrollment/disenrollment as they are allowed to change plans throughout the year. Even though the Plan makes conscientious efforts to follow up on every patient regardless of their continuous enrollment status via transition of care, discharge calling, and intensive case management, those efforts might be unaccounted for in all of the calculations that take into consideration the reported rates for readmission. Additionally, the beneficiaries in DSNP programs tend to have greater co-morbidities that are consistent with their outlined conditions that caused the admission in the first place. While readmission measures are based on continuous enrollment, the greater rate of attrition means that only a subset of efforts applied consistently across members are taken into consideration as they are admitted and discharged throughout the year.

DSNP beneficiaries have a lower socio-economic status and studies have shown that it has a direct correlation with disparities in health care, higher food insecurity leading to higher rates of obesity and less access to healthy foods, fewer opportunities for physical activity thus higher number with sedentary lifestyles, and higher stress (http://frac.org/initiatives/hunger-and-obesity/why-are-low-income-and-food-insecure-people-vulnerable-to-obesity/). The lower socio-economic status is more likely to have been present throughout the lifecycle in Duals vs. Non-Duals. This contributes to findings that Duals are often sicker than their Non-Dual counterparts of similar age.

Lastly, DSNP beneficiaries are more likely to acquire chronic conditions and conditions which require long-term treatment. This causes additional risk of admission/readmission and has a significant impact on the Plan's overall performance and ability to positively impact the beneficiary's health status.

Medicaid vs. Medicare HEDIS Performance

NCQA publishes yearly percentiles for quality reporting of the National Standards for HEDIS reporting. Although not all Plans are required to report and not all measures apply to both Medicaid and Medicare products, the data underlines lower performance for Medicaid versus

Medicare Products. When analyzing the compliance for certain measures, the difference between both populations' performance is clear and significant. As an example and as published the "2013 HEDIS Audit Means, Percentiles" spreadsheet, the Adults' Access to Preventive/Ambulatory Health Services (AAP) measure gives us a clear picture of the performance difference between one population and the other. In such document and when filtering by measure and reporting LOB, the AAP mean for the "Total" sub measure reports a national mean for Medicaid of 82.65% while the same for Medicare reports a 94.9%.

The above is consistent across the board and can be observed in other measures. Some include but are not limited to Antidepressant Medication Management (AMM) "Acute Phase Treatment" where the difference in the national mean is 16.58% points with the Medicaid mean being at 52.82% while the Medicare mean is at 69.4%. When analyzing the performance of some of the STARs measures which are reported for both products, we can also see a clear and significant difference. The Breast Cancer Screening (BCS) measure is another outlier in performance of Medicare over Medicaid. The 2013 national mean for the measure is 51.87% for Medicaid and 69.91% for Medicare. One can note that higher performance is more likely to be achieved by Medicare beneficiaries. The highest reported percentile is at 95% where only the top 5% of Health Plans are ranked. In that percentile, the plans are above 65.16% for Medicaid productions while 84.75% for Medicare products. We can reference that the difference of high performing health plans' reported threshold is almost 20% points different for Medicaid and Medicare.

Enrollment/Disenrollment

Another issue to consider when looking at the difference between DSNP and MA beneficiaries is the ability/inability to enroll/disenroll at any time during the year. While MA beneficiaries are subject to lock-in provisions, DSNP beneficiaries can move freely between plans and to FFS Medicare. This is an issue that has many ramifications and directly affects the ability of the Plan to influence the patient's behavior and compliance to preventive and proactive treatment.

In the Plan, we looked at our disenrollment from January to December of 2013. During the review period, we have observed a much higher disenrollment rate for those enrollees in the Dual Plans compared to those in the Non-Dual. The Plan tried to replicate the measure from the CMS STARS Technical Specifications and removed involuntary disenrollments. During the review period, the Plan saw an average disenrollment rate of 28% for those beneficiaries enrolled in our DSNP products. At the same time, we considered the Non-DSNP beneficiaries enrolled at any time in the Plan and observed an average disenrollment rate of 23%.

Conclusion

There are many publicly reported studies that have outlined the differences of performance, behavior, and ability to influence for beneficiaries of DSNP versus MA products. It is clearly demonstrated that the performance is lower for DSNP beneficiaries which is not a true reflection of the Plan's commitment and conscientious efforts towards positively influencing such enrollees towards making better choices, allocation of resources, and dedication to long-term improvement and decrease of co-morbidities and risk. For those health plans like the Plan who report both DSNP and Non-DSNP beneficiaries under the same contract ID, it is observed that they would be at a significant disadvantage unless there is an appropriate measure of adjustment. Such Plans may also be subject to penalties, reduced capitation rates, and even lower probability to access of additional resources (QBP included) unless a significant case mix adjustment is performed.

Currently, only the CAHPS measures under the STARs program are adjusted to account for the lower performance of the DSNP beneficiaries. This adjustment is based on geographic and demographic factors that must be taken into consideration and used for all other measures that demonstrate a lower performance when reported combined with MA and DSNP beneficiaries. Such measures include but are not limited to the all HEDIS measures, Involuntary Disenrollment, and Part D Medication Adherence measures. We propose that the adjustment is based under the same correlation as the one already performed for the CAHPS measures which will allow for an even playing field for all Plans across the nation but, above all, access to better quality of care and services to all beneficiaries who are enrolled in a MA or MA-PD plan. It will also give greater and richer benefits as Plans can use those additional resources to ensure beneficiaries are appropriately educated, use and access to preventive and routine services, and added benefits like dental, transportation, meals, and other services not outlined currently in the schedule of benefits.