November 3, 2014

Honorable Marilyn B. Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
Baltimore, MD 21244-1850

Re: CMS RFI: "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,

As there are substantial economic and health disparities between the Medicare Advantage and Medicare SNP population, *i*Care appreciates this opportunity to provide information in response to the CMS RFI. It is encouraging to note that policy makers are beginning to question the appropriateness of evaluate both types of plans using universal star measures. This response provides *i*Care's experience regarding effective strategies and procedures for optimizing star-measure ratings, and also identifies challenges and recommendations for Medicare SNP measures.

1. Introduction

Independent Care Health Plan (*i*Care) serves nearly 6,000 dually-eligible members under CMS contract H2237. Predominantly drawing from the disadvantaged, inner-city population of Milwaukee, *i*Care serves only low-income beneficiaries eligible for Medicaid, and does not offer plans for active seniors or commercial population. The *i*Care Medicare program includes both a D-SNP and a FIDESNP.

While iCare stands ready to provide CMS with a rich set of experiences regarding the disparity between dually-eligible and traditional Medicare populations, its relatively compact size precludes the level of statistical power and evidence that CMS seeks. As a result, this response incorporates findings from Inovalon, a technology company that uses data analytics and data-driven interventions to achieve impact in clinical and quality outcomes, utilization, and financial performance in the healthcare field.

Inovalon conducted a study to better understand the factors that contribute to the poor performance of dual eligibles on five-star quality measures. The study, entitled "An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures," showed a significant disparity in the performance between the dual and non-dual Medicare populations. The newly-released study states that dual eligibles have "significantly different clinical, demographic and socioeconomic profiles compared to non-dual MA members that result in worse performance on a majority of the measures evaluated. The results show that dual eligible members perform significantly

worse on 10 of the 18 measures evaluated (56%) and on 6 of the 8 current Star measures studied (75%)."

The following outlines several universal Medicare five-star measures and the procedures, strategies, challenges and suggestions *i*Care has associated with each one. This letter touches only on five-star measures that *i*Care has been able to positively impact despite the challenges posed by the dually-eligible population. The population has not responded on many other measures in spite of substantial investment of resources by iCare; these measures are not outlined in this letter.

For your convenience, the five-star measures have been grouped into several different categories based on shared policy recommendations that would serve to alleviate the challenges associated with each measure.

2. Policy Recommendation: Global Information Sharing

The following five-star measures – BMI, Functional Assessment and Pain Screening, Medication Review, Diabetes Control, High Blood Pressure Control, Nephropathy Care and SNP Care Plan – share a policy recommendation of global information sharing between providers and health plans. This recommendation is articulated at the end of this section.

a. **Measure:** BMI

***i*Care's BY13, CY15 Star Rating:** 3

Successful Strategies:

- The procedures that have proven effective in increasing the star rating for the BMI measure center on having ready access to members' medical records for review.
- Provider education regarding correct coding on claims has also enhanced *i*Care's ability to improve this measure.
- These factors allow *i*Care staff to efficiently collect information from medical records and provider claims to ensure that all members who receive BMI testing are accurately recorded and accounted for.

b. **Measures:** Functional Assessment and Pain Screening

***i*Care's BY13, CY15 Star Rating:** functional assessment: 5, pain screening: 5

Successful Strategies:

- One strategy that has helped increase the star measure rating for functional assessments at *i*Care has been a relatively simple re-ordering of questions posed to members in the in-home functional assessment questionnaire.
- Early *i*Care efforts involved placing five-star measure questions at the end of the in-home assessment questionnaire. Care teams have found it beneficial to begin the

assessment with the five-star measure questions in case the questionnaire is not completed in the first visit.
- This ensures that the five-star measure questions are answered immediately and can be entered in the system as soon as possible.

c. **Measure:** Medication Review

***i*Care's BY13, CY15 Star Rating:** 4

Successful Strategies:

- Access to data and information from innovative pharmacy providers has helped *i*Care increase the medication review star rating.
- *i*Care works with HAYAT pharmacy, an innovative pharmacy in Milwaukee County that provides a Medication Therapy Management program (one-on-one patient counseling), a Simplify My Meds program (synchronizes a member's medications so that all prescriptions are filled on the same day each month), as well as free home-delivery.
- The local neighborhood and community focus of the HAYAT pharmacy includes a program allowing its pharmacists to perform in-home visits and consultations with members.
- While HAYAT has made a significant improvement in *i*Care's ability engage inner-city members, data sharing programs with all pharmacies have also improved star ratings. *i*Care receives medication therapy management data from pharmacists, which provides thorough information regarding members' medications, medication history and reactions to these meds.
- In addition, *i*Care's teams of employed nurse practitioners perform medication reviews with select high-needs members, which has also helped to optimize star-ratings.

d. **Measures:** Diabetes Control and High Blood Pressure Control

***i*Care's BY13, CY15 Star Rating:** Diabetes: 2; and HBP control: 4

Inovalon Data: The Inovalon study of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures notes the following:

- The medication adherence rate for diabetes among dual eligibles is 71.9%, compared to a rate of 73.3% for non-dual eligibles
- The medication adherence rate for hypertension (abnormally high blood pressure) among dual eligibles is 72.2%, compared to a rate of 75.2% for non-dual eligibles.

Successful Strategies:

- Notwithstanding the disparities noted by Inovalon above, *i*Care has successfully increased its performance on this measure through provider information sharing.
- Efforts to gain timely access to provider records have had the largest impact on *i*Care's ability to accurately measure diabetes control (HbA1c <9%) and High Blood Pressure Control (HBP Control).

e. **Measure:** Nephropathy Care

***i*Care's BY13, CY15 Star Rating:** 4

Successful Strategies:

- Star measure improvement at *i*Care has resulted primarily by applying additional resources to medical record review and provider outreach.
- Nephropathy care and corresponding testing is primarily done in the office of a physician. Routine information sharing and medical record reviews are the primary strategies of focus when optimizing this star measure.

Policy Recommendation: Each of the measures outlined above shares a common data source – providers. Policy guidance to improve five-star performance includes the following.

a. *i*Care recommends firm regulatory guidelines requiring providers to share information with health plans to ensure accurate and optimal star-measure ratings.
    i. There is evidence that some providers are withholding performance measurement information from other providers and from plans pending payment for that information.
    ii. For instance, the quality of the *i*Care plan is assessed in part for diabetes and HBP control. *i*Care knows from its claims stream whether it has paid or not paid for a laboratory test. It frequently happens that when *i*Care approaches the laboratory for the test results (e.g., indicating whether the member's diabetes is under control or not), the laboratory demands (or the health system that owns the laboratory demands) additional payment for the results, effectively increasing the plan's administrative costs, knowing that *i*Care needs that information for its 5-Star performance reports.
    iii. Other D-SNPs have shared similar experiences during trade association meetings.
    iv. The result of holding this information "hostage" is that the performance for dually-eligible cases is under-reported; those cases remain in the denominator but their achievement of control cannot be reported in the numerator, depressing the measure's score.
    v. To achieve accuracy in duals performance reporting, withholding performance-sensitive information needs to be a regulatory offense; at the moment it is not.
b. *i*Care suggests more shared-responsibility measures to consolidate efforts and focus each of the members' providers, including PCPs, hospitals, nursing homes, home health agencies and *i*Care in the same direction of optimal member health.

i. Perhaps a target could be set that at least five "shared accountability measures" be created to produce collaborative dependency between plans and providers, requiring their coordination of resources and cooperation toward the same end.
ii. Evidence of this "force multiplier" effect can be seen in readmission prevention. This measure is the only one currently encompassing plans and providers. Since all parties are working toward a common goal, nation-wide readmission performance has, indeed, improved.

c. One challenge associated with many star measures is the receipt of accurate diagnostic codes from providers, often times because there is more than one code per star-measured test.
   i. *i*Care recommends simplification of coding and claim submission requirements for five-star items.
   ii. Perhaps a consolidated code can be developed where multiple codes exist.

3. Policy Recommendation: Enhanced Public Education

The following five-star measures –Colorectal and Retinal Eye Exams– share a policy recommendation of enhanced public education. Enhanced education would help eliminate the fear and cultural bias associated with these exams.

a. **Measure:** Colorectal Exams

***i*Care's BY13, CY15 Star Rating:** 5

Successful Strategies:

- *i*Care has found that use of mailed at-home colorectal exam test kits (Fecal Immunochemical Tests, also called FIT) has substantially increased the number of members that willingly receive colorectal exams.
- In addition, the use of gift cards as an incentive has been of great benefit.

b. **Measure:** Retinal Eye Exams

***i*Care's BY13, CY15 Star Rating:** 4

Successful Strategies:

- Two strategies that *i*Care has found helpful in incentivizing members to receive retinal eye exams are (1) using gift cards as a reward; and (2) partnering with retinal eye exam vendors on shared outreach campaigns.

Policy Recommendation: *i*Care believes that better education regarding these two exams would reinforce their importance, mitigate fear and lessen any cultural bias. A public information campaign, led by CMS, may help to alleviate these factors.

a. Retinal eye exams pose two challenges. The first is that members do not want to be subject to eye dilation, and the second is that many members do not feel the test is necessary.

b. A challenge associated with colorectal exams is the fear of discomfort, often rooted in a lack of education or misinformation about the test.
c. In addition, there are cultural biases that prevent certain members from undergoing a colorectal exam.

4. Additional Items and Policy Recommendations

The following five-star measures also capture successful strategies implemented by *i*Care. Each could be even more effective through careful public policy consideration. Unlike the previous two sections, these measures do not lend themselves to a single, common policy change. The successfully-deployed strategies and policy recommendations are listed for each individual measure below.

a. **Measure:** SNP Care Plan

***i*Care's BY13, CY15 Star Rating:** 1

Successful Strategies:

- *i*Care utilizes in-home assessment providers that create supplemental assessments, which *i*Care care teams can use in their care plans.
- In-home assessments are extremely valuable in that this form of testing has an impact on several of the star measures. It creates an additional opportunity for the care teams to address and assess measures.

Recommendation:

- One challenge associated with this measure is the 365-day schedule limitation on performing the in-home assessments, rather than an annual limitation.
- This can be problematic and inefficient for care teams because it requires that the care team perform the test every 365 days, versus annually. An annual requirement would allow staff more flexibility to schedule an assessment conveniently for beneficiaries.

b. **Measure:** Osteoporosis

***i*Care's BY13, CY15 Star Rating:** 3

Successful Strategies:

- The strategy that has provided the greatest impact on osteoporosis management has been the use of in-home bone-density tests performed by nurse practitioners.
- The nurse practitioners are qualified to perform the testing with a machine that can be set up in a member's home.

- This test can also be done in a physician's office, but bringing the test into the home is more convenient for the member and reduces any risk of complication with transportation or no-shows.

Recommendation:

- *i*Care recommends incentives and block grants to local community organizations to invest in in-home bone density testing equipment. This equipment is fragile, and not easily transported between cities.

- Local investment will increase the availability of in-home bone-density testing.

c. **Measure:** Breast Cancer Screening (BCS)

***i*Care's BY13, CY15 Star Rating:** 4

Inovalon Data: The Inovalon study of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures notes the following:

- 74.8% of duals undergo breast cancer screening compared to 77.3% of non-dual members, a statistically significant difference.
- Dual eligible women age 70-74 have screening rates 6% lower than non-dual females in that age demographic.
- Black and White dual females have BCS less than non-dual females in those race/ethnic groups (-3% and -8% respectively) but Hispanic dual eligible women have BCS more frequently (+5%).
- Dual women living in small or isolated rural areas have BCS done 13-17% less than non-dual women living in those areas.

Successful Strategies:

- iCare has found a few different strategies that help incentivize members to receive mammograms. These incentives include gift cards for members for receiving the exam, as well as sponsoring an "Aurora Mammography Day" at an Aurora HealthCare clinic for members to receive mammograms. Aurora Health Care is a not-for-profit health care system headquartered in Milwaukee and serving eastern Wisconsin. Aurora has 15 hospitals, 185 clinics, and more than 80 community pharmacies, which provides *i*Care members with ready access to several locations across Wisconsin.
- Mammography day is effective in incentivizing members to undergo a mammogram exam because the clinic is conveniently located in the same building as *i*Care's Milwaukee office, thus members are familiar with the location and care teams are only an elevator ride away should the member need any assistance or consultation.

- In addition, having a concentrated day centered on mammograms is beneficial since care coordinators are able to call their members to advertise the day, schedule an exam and remind them of the appointment.

Recommendations:

- *i*Care recommends eliminating this measure or reducing the frequency at which members must undergo a breast cancer screening. The rationale behind this suggestion stems from the attached study performed by BMJ (formerly the British Medical Journal), which concluded that "annual mammography in women aged 40-59 does not reduce mortality from breast cancer beyond that of physical examination or usual care when adjuvant therapy for breast cancer is freely available." (Please see attached study.)

d. **Measure:** DMARD (Anti-Rheumatic Care)

***i*Care's BY13, CY15 Star Rating:** 4

Inovalon Data: The Inovalon study of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures notes the following:

- Older duals age 80-84 perform 10.8% worse than non-duals in this age bracket.
- Dual males perform 16% worse than non-dual males.
- Duals living in an isolated rural area perform 10% worse than non-duals living in those areas.
- Duals with no low income drug subsidy perform 13% worse.
- Duals with five or fewer outpatient visits per year perform 10.7% worse; in contrast, duals with 16 or more visits that perform only 4.5% worse compared to non-duals with as many office visits.
- Duals taking fewer than 7 different medications perform 14% worse on this measure. Duals taking 7 or more drugs performed 6% worse.

Successful Strategies:

- *i*Care's most effective strategy to ensuring optimal anti-rheumatic care is to administer in-home disease management programs on a customized individual member basis.

Recommendation:

- The biggest challenge associated with this star-measure is that many members cannot take anti-rheumatic drugs because these medications interfere with other medical diagnoses and medications.

- For example, biologic DMARDs are TNF inhibitors, which suppress the immune system and would pose substantial health risks in someone with an immunodeficiency.
- iCare suggests that these interactions be taken into account for Medicare-SNP members, as this population often has multiple conditions that may prevent use of DMARDs.
- CMS may wish to consider eliminating this measure entirely for D-SNPs.

5. Discussion and Further Analysis

The preceding sections demonstrate the importance of information-sharing between plans and providers. In many cases, providers do not collaborate with plans. Other barriers, such as legal action, result in denying plans access to information.

In these situations, the method for measure calculation is decidedly biased against plans. This is true for measures requiring not only require proof of test performance, but also the result of the test performed. Please consider the following example related to diabetic control measures:

- Measure C16 is based on the number of diabetic enrollees 18-75. This number forms the measure denominator.
- The numerator is 100 minus the number of diabetic enrollees 18-75 whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year.
- In most cases, *i*Care can demonstrate that a member had an A-1-C lab test during the year. This information is accessible through claims data.
- However, the claims data does not carry the HbA1c level. As noted previously, providers must agree to supply this information to *i*Care. Providers may withhold this information from *i*Care for any reason desired, even though *i*Care has correctly paid for the test.
- CMS does not nullify a lab test when providers withhold information from plans. Instead, CMS assumes that the HbA1c level exceeded 9%, and that HbA1c control was poor. This assumption is made regardless of the actual HbA1c level.

Provider withholds of such information may result in the false impression of adverse SES impact when, in fact, such withholds point to system dysfunction. A more accurate calculation would simply remove these lab tests from both the numerator and the denominator. Adjusting this measurement will avoid distorting and falsifying the data and corresponding star measure.

A similar bias can be found in measure C08, Adult BMI Assessment.

- It is routine for a member's height and weight to be measured and recorded at each doctor visit.
- As BMI is calculated by dividing weight by height in inches squared and multiplying by a conversion factor of 703, physicians often perform this calculation and verbalize it to the member without documenting the calculation in a member's chart.

- Even though the physician visit included height measurement, weight measurement and a discussion of BMI with the member, absence of the calculated level in the chart nullifies these activities. The star measure rating system assumes that the BMI test was never performed or articulated to the member.

The result is that *i*Care will underreport the level of BMI Assessments completed among its dually-eligible population. While *i*Care understands the significant impact of SES on star ratings, the depressing impact on ratings caused when providers withhold data cannot be disregarded.

6. Summary and Conclusion

As discussed, *i*Care has identified the challenges associated with working with a special needs population. These challenges advocate for policy change that will create a set of measures more suitable for Medicare beneficiaries that qualify for a special needs plan. Overall, *i*Care suggests more information sharing, more shared-responsibility measures, and new, innovative measures that take into account the unique needs and lifestyle variance of a special needs population.

In addition, *i*Care encourages CMS to consider the impact providers have over health plan scores when data such as lab test results are withheld. Methods to account for this absence of data will improve the accuracy of the star rating system and allow for stronger measurement of SES population outcomes.

Given the significant challenges posted to plans that exclusively serve a dual eligible population, iCare recommends use of a different set of measures than those applied to traditional Medicare Advantage populations. Currently, *i*Care is participating in a study conducted by the National Committee for Quality Assurance (NCQA). This study seeks to identify best practices surrounding member-centered care planning.

- Member-centered outcomes are the desired outcomes that the member and his or her care team have established for the member given the member's health status and long-term health goals.
- These goals are documented by the member's care team in the member-centered care plan, which is plan that is created after a member's care performs a health assessment.
- Health assessments are performed every six months to ensure that the member's care plan and determined outcomes remain accurate and appropriate. The member centered plan is used as a roadmap for how best to assist the member, documents the member's diagnoses and addresses any present health and safety concerns.

CMS may wish to consider that this population would be best served by measures that evaluate progress made in reaching member-centered outcomes. At *i*Care, care plan reviews are performed to ensure that the outcomes identified in the care plan show evidence of guidance by the member, are achievable and meaningful. Therefore, a member's achievement or progress made toward achieving desired outcomes is a more reflective and appropriate evaluation of Medicare SNP plans' service delivery than the current five-star measures.

Thank you once again for this opportunity to provide input to this critical area of decision-making. If iCare can provide additional information, please do not hesitate to contact me at (414) 225-4777 or tlutzow@icare-wi.org.

Sincerely,

Thomas Lutzow, PhD, MBA
President & CEO, *i*Care