

Health Net - RFI Response on Impact of Dual Eligible/LIS Status on Star Ratings

Introduction

Health Net is grateful for this opportunity to respond to CMS's Request for Information regarding Data on Differences in Medicare Advantage and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees.

This is a very important topic. As noted in the RFI, the Star Ratings system has the potential to foster continuous quality improvement in the Medicare Advantage (MA) and Medicare Prescription Drug Program, including for unique populations such as dual eligible beneficiaries or Low Income Subsidy (LIS) beneficiaries. For the Star Ratings system to be successful in doing this requires that it reflect, as accurately as possible, plans' efforts and successes in implementing the types of activities, processes, and systems that encourage the best possible outcomes for each beneficiary population.

On the other hand, if the measures and ratings system do not accurately measure quality for certain populations, or if they encourage comparisons among plans that are not "apples to apples" comparisons, the system is less likely to succeed at encouraging innovation, competition, and investment in activities that produce higher quality care for these populations, and may even create unintended consequences related to enrollment and plan option availability for certain populations. This is especially concerning for populations, such as dual eligible beneficiaries, including those enrolled in Dual Eligible Special Needs Plans (D-SNPs), and LIS beneficiaries, which may present unique characteristics and thus require a unique focus in providing high quality care.

As noted in the RFI, there is evidence of an association between higher dual-eligible enrollment (and higher LIS beneficiary enrollment) and lower Star Ratings. Health Net hopes that the information provided in this response can be helpful in providing insights into what factors may be underlying this correlation, including the specific measures on which dual/LIS beneficiaries seem to have lower performance and the underlying factors that may explain this. We hope that this will be helpful as CMS considers appropriate adjustments to encourage high-quality care to these vulnerable populations. There is also precedent for seeking to address these issues, with examples provided for in CAHPS and HEDIS star measures.

Notes on the Methodology

While the methodology is described in greater detail below, we wanted to note that this analysis (as was noted would be helpful in the RFI) includes data from all contracts under the Health Net, Inc. parent organization, across all of the states in which Health Net participates in Medicare, except where otherwise noted. It is thus intended to provide comprehensive data and robust analysis about this population and the potential factors underlying the correlation between quality scores and dual/LIS status.

While causality is difficult to establish without an experimental design, it is possible to use multivariate modeling to establish the relationship between D-SNP or LIS status and quality measures, while holding other key variables fixed.

In addition to annual HEDIS calculation and submission, Health Net employs software which produces bi-monthly HEDIS® results for Part C and D Star and Display measures to track contract performance. While the data produced using this software is not what is used for the official HEDIS® reporting purposes, It is based on the same data source, relies on the same specifications and where applicable is certified by the same appropriate organization. Health Net used this data to for all subsequent analysis related to HEDIS and/or PQA Star measures presented in this document. Wherever possible, data was aggregated across all Health Net contracts to provide additional explanatory power. Data is based on standard, namely administrative, data sources only. All analysis was conducted using SAS® version 9.4.

Overview of Health Net Special Needs Plans

In addition to the core benefits available to all Health Net Medicare beneficiaries, Health Net also provides additional benefits to SNP members. Additional benefits such as dental, routine vision, eyewear, transportation services, membership in a fitness program, hearing aids or reduced costs for items such as Diabetic Monitoring supplies and Oxygen are provided – actual benefits vary by region and type of SNP. Additionally, full-benefit dual-eligible members have no out-of-pocket expenses for medical coverage and receive prescription medication savings through LIS. Actual cost-sharing is based on the member's income level. All SNP members are included in the Medication Therapy Management (MTM) program. MTM requires that a pharmacist reviews medication profile quarterly and communicates with member and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues. Lastly, all SNP members are assigned a case manager and have a customized care plan created to address their specific needs.

Overview

Based on the data we have reviewed, it appears that a number of factors contribute to lower Star Rating performance for plans with a high proportion of D-SNP or LIS beneficiaries. For example, factors such as age, number of Hierarchical Condition Categories (HCCs), and gender can have an impact on specific measures in the Star Ratings system. However, we noted that, even when controlling for these factors, D-SNP members are likely to have poorer outcomes as compared to non D-SNP members.

A review of the data provides some insights into what may be driving this. In particular, it appears that, when other factors are controlled for, socioeconomic status, as determined by LIS eligibility, may be a contributing factor. As discussed in greater detail below, there was also a relationship between individuals living in zip codes with high poverty rates (based on census data) and poorer outcomes.

We also provide data describing some specific measures on which dual eligible or LIS beneficiaries tend to have poorer outcomes. Overall, we found evidence that when compared to other beneficiaries, dual eligible or LIS beneficiaries have lower scores when it comes to general preventive screenings, have average or higher scores with regard to receiving care for existing diseases (such as diabetes), and have lower outcomes in measures of medication adherence.

We do not believe the analysis suggests any significant difference in plan benefits or structure that leads to this distinction. As noted above, this correlation persists despite the fact that Health Net SNPs

provide several additional benefits to SNP plan members. Rather, we believe that other factors, related to beneficiary characteristics, can be identified that contribute to the difference in star measure outcomes. For example, one practical concern as described below is that, plans and providers have greater difficulty contacting/LIS members to encourage necessary screenings, preventive care and effective follow-up, despite employing various member engagement efforts. This is important to recognize as the agency considers how to develop incentives for plans using the Star Rating program.

Evidence of the general correlation between D-SNP / LIS status and low Star Ratings

Several organizations have demonstrated an association between higher proportions of dual-eligible SNP beneficiaries or Low Income Subsidy beneficiaries and lower overall Star Ratings on average. Most recently, America’s Health Insurance Plans (AHIP) published an article on the Health Affairs Blog titled *Medicare Advantage: Stars System’s Disproportionate Impact On MA Plans Focusing On Low-Income Populations*. The article provides data which supports the concept that Medicare contracts which serve low-income populations encounter systematic challenges in quality measurement because of the populations they serve.

Health Net has also demonstrated similar findings using the same publicly reported CMS Star Rating data for Contract Year 2015. As D-SNP proportion in contracts increase, the average Star Ratings decrease (Chart 1). Plans with less than 10-percent overall D-SNP membership have the highest average Star Rating. A similar relationship can be seen when comparing average Star Rating by proportion of members with LIS status (Chart 2).

Chart 1– CY2015 Average Star Rating by Contract Percent D-SNP

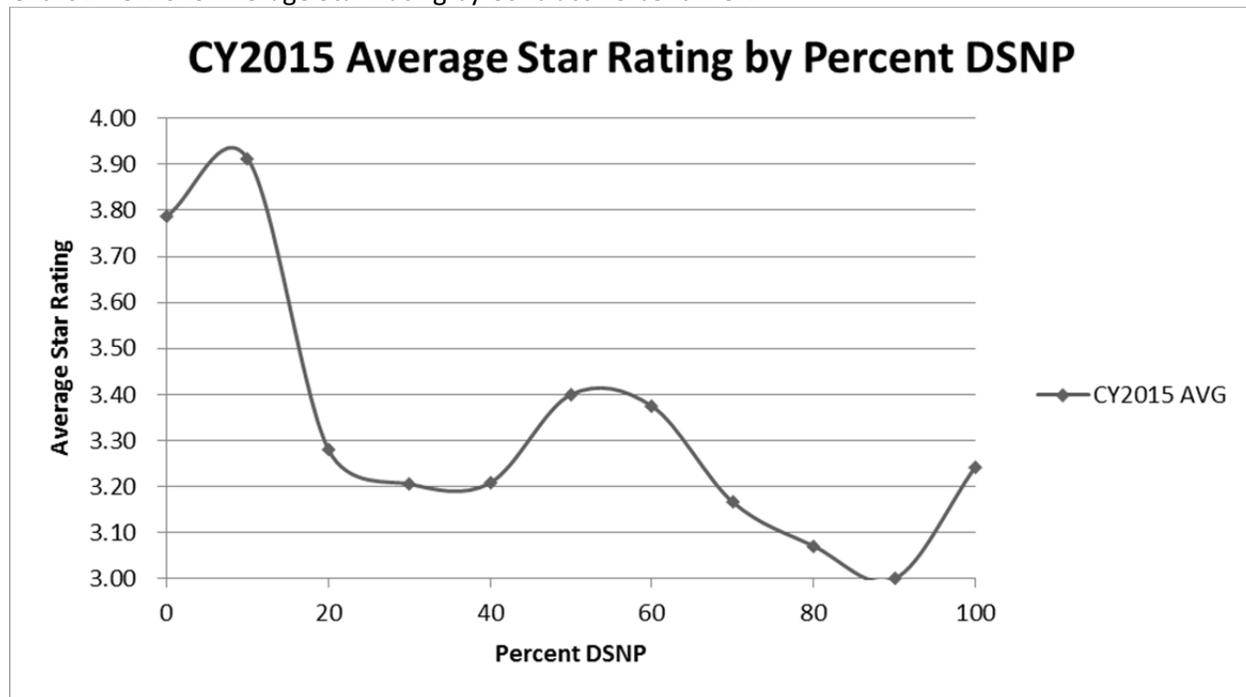
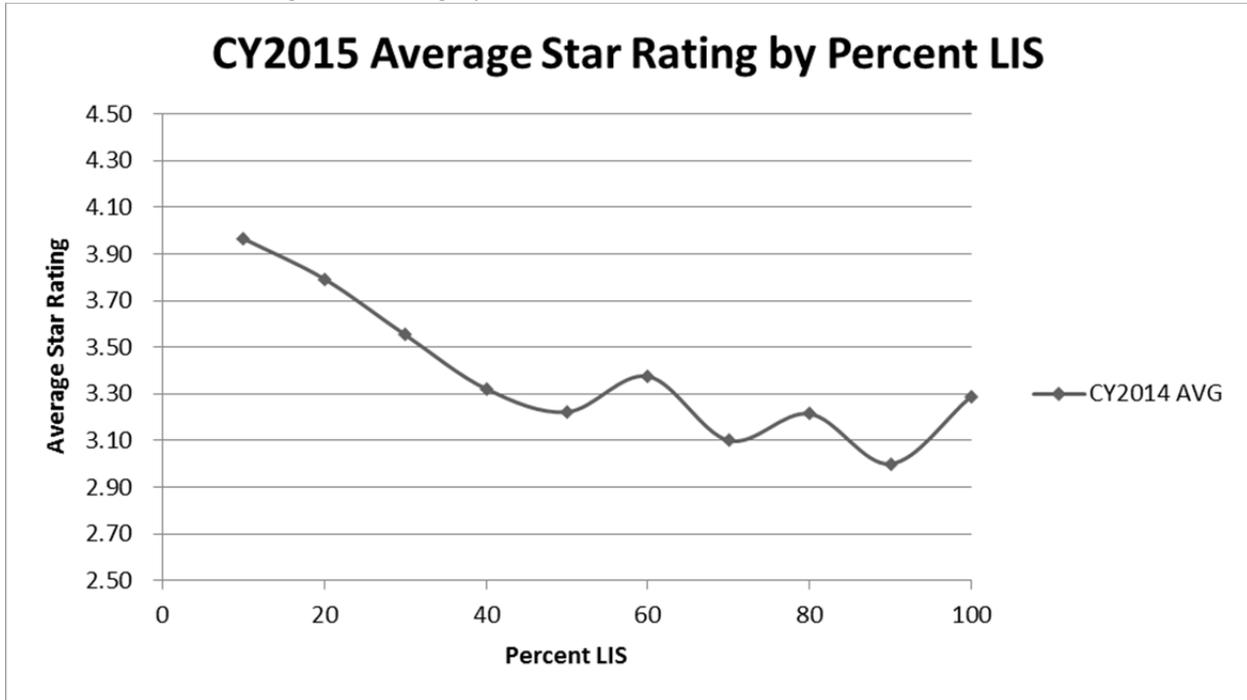


Chart 2 – CY2015 Average Star Rating by Contract Percent LIS



Effect of socioeconomic factors

Our data and analysis suggests that socioeconomic factors may play a key role in explaining differences in performance on the star measures, regardless of whether an individual is in a D-SNP. To better examine this, using Federal Poverty Level data from the US Census American Community Survey, we classified beneficiaries, based on their zip codes, into four strata based on the percent of poverty for each zip code (Table 1). We found a relationship between individuals living in high-poverty zip codes and lower scores on certain quality measures. This relationship exists both when comparing members within D-SNP plans and also when comparing members outside of D-SNP plans (Charts 3 and 4).

Table 1 – Health Net derived Federal Poverty Level (FPL) class for all contracts – Percent D-SNP and LIS Members

Health Net Derived FPL Class	FPL (%) for zip code of residence	Approximate Members	D-SNP (%)	LIS (%)
Class 1	<7.4	46,041	5%	10%
Class 2	7.4-12.6	67,364	7%	15%
Class 3	12.6-20.8	78,143	15%	25%
Class 4	>=20.8	56,479	28%	41%

Chart 3 – CY2015 Compliance rate for Colorectal Cancer screening Star Measure by D-SNP Status and Federal Poverty Level (FPL) in Zip Code of Residence

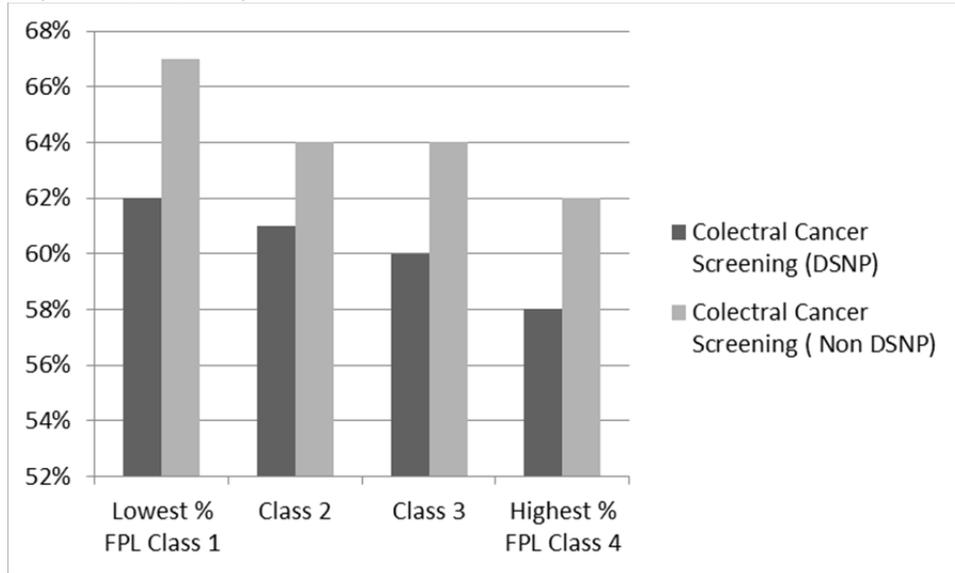
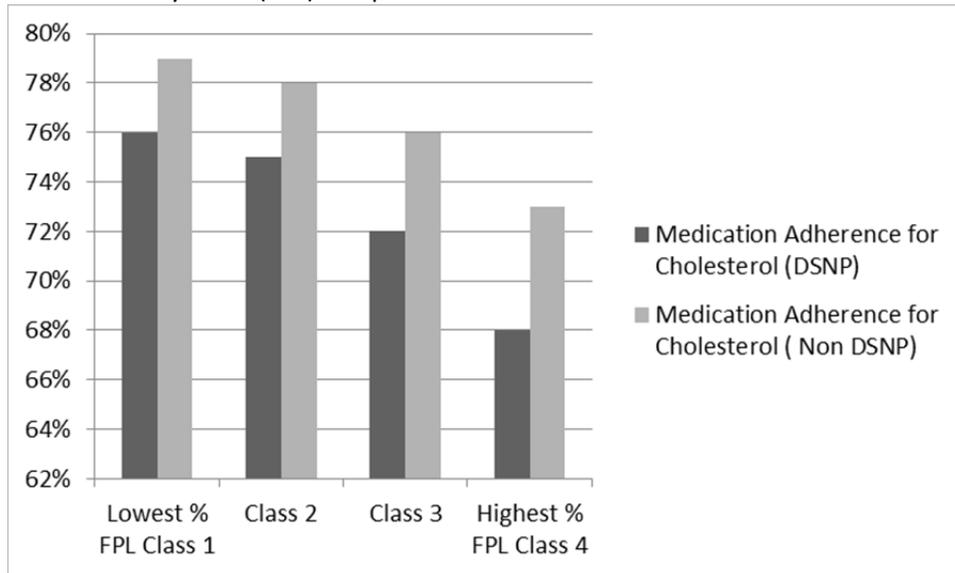


Chart 4 – CY2015 Compliance rate for Medication Adherence for Cholesterol Star Measure by D-SNP Status and Federal Poverty Level (FPL) in Zip Code of Residence



Please note that even within a given FPL quartile, there are differences between outcomes for Non D-SNP and D-SNP enrollees. This suggests that the poverty status of the community in which the person lives explains some, but not all of the differences noted in quality outcomes.

Specific measures

It may be helpful, in considering any adjustments, to examine the specific measures on which dual eligible beneficiaries or LIS beneficiaries have lower outcomes. While overall performance on the Star Ratings is lower, this is not spread evenly across all measures. Rather, there seem to be certain types of measures in which dual eligible or LIS status makes a significant difference.

For many clinical measures in both Part C and D, D-SNPs underperform non-D-SNPs (Table 2). Specifically, the impact is observed for certain cancer and chronic condition screening services and medication adherence. Similarly, outcomes for members who are in the LIS program are often lower than those who do not receive LIS (Table 3).

Table 2 – CY2015 Rate comparison for all HMO Contracts comparison of clinical measures (D-SNP versus Non D-SNP members)

Star Measure	D-SNP	Non D-SNP	Difference	D-SNP Performance
Breast Cancer Screening	69%	77%	-8%	Worse [†]
Colorectal Cancer Screening	57%	63%	-5%	Worse [†]
Cardiovascular Care - Cholesterol Screening	86%	91%	-4%	Worse [†]
Diabetes Care - Cholesterol Screening	89%	91%	-2%	Worse [†]
COA for SNP mbrs - Medication Review	99%	100%	0%	Same
COA for SNP mbrs - Functional Status Assessment	49%	49%	0%	Same
COA for SNP mbrs - Pain Screening	47%	51%	-4%	Worse [†]
Osteoporosis Management in Women who had a Fracture	26%	31%	-4%	Worse
Diabetes Care - Eye Exam	55%	57%	-2%	Worse [†]
Diabetes Care - Kidney Disease Monitoring	93%	91%	2%	Better [†]
Diabetes Care - Blood Sugar Controlled	67%	65%	2%	Better [†]
Diabetes Care - Cholesterol Controlled	50%	50%	0%	Same
Rheumatoid Arthritis Management	72%	76%	-4%	Worse
Plan All Cause Readmission*	13%	11%	1%	Worse [†]
High Risk Medication*	10%	10%	0%	Better [†]
Diabetes Treatment	89%	88%	2%	Better [†]
Medication Adherence - Oral Diabetes Medications	77%	78%	-1%	Worse [†]
Medication Adherence for Hypertension (ACEI or ARB)	76%	80%	-4%	Worse [†]
Medication Adherence for Cholesterol (Statins)	71%	76%	-5%	Worse [†]

*Inverted Measure - Lower Rate indicates higher performance

Note: Data is based on Administrative Sources only and rounded to nearest whole number. PCR measure is not case mixed, but is the actual readmission rate.

[†] Difference is statistically significant at P<=0.05

Table 3 – CY2015 Rate comparison for all HMO Contracts comparison of clinical measures (LIS versus Non LIS members)

Star Measure	LIS	No LIS	Delta	LIS Performance
Breast Cancer Screening	68%	77%	-9%	Worse [†]
Colorectal Cancer Screening	54%	60%	-6%	Worse [†]
Cardiovascular Care - Cholesterol Screening	87%	90%	-3%	Worse [†]
Diabetes Care - Cholesterol Screening	88%	90%	-2%	Worse [†]
COA for SNP mbrs - Medication Review	99%	100%	-1%	Worse
COA for SNP mbrs - Functional Status Assessment	49%	49%	0%	Same
COA for SNP mbrs - Pain Screening	48%	51%	-3%	Worse [†]
Osteoporosis Management in Women who had a Fracture	27%	31%	-4%	Worse [†]
Diabetes Care - Eye Exam	53%	57%	-4%	Worse [†]
Diabetes Care - Kidney Disease Monitoring	92%	90%	2%	Better [†]
Diabetes Care - Blood Sugar Controlled	59%	57%	2%	Better [†]
Diabetes Care - Cholesterol Controlled	45%	45%	0%	Same
Rheumatoid Arthritis Management	75%	77%	-2%	Worse
Plan All Cause Readmission*	14%	11%	3%	Worse [†]
High Risk Medication*	11%	10%	1%	Worse [†]
Diabetes Treatment	88%	88%	0%	Same
Medication Adherence - Oral Diabetes Medications	78%	78%	0%	Same
Medication Adherence for Hypertension (ACEI or ARB)	77%	81%	-4%	Worse [†]
Medication Adherence for Cholesterol (Statins)	72%	77%	-5%	Worse [†]

*Inverted Measure - Lower Rate indicates higher performance

Note: Data is based on Administrative Sources only and rounded to nearest whole number. PCR measure is not case mixed, but is the actual readmission rate.

[†] Difference is statistically significant at P<=0.05

To more robustly compare outcomes on clinical measures, Health Net applied logistic regression where the outcome was beneficiary compliance on clinical measures during the CY2015 Star Rating period (2013 measurement year). Two separate models were employed to evaluate both the effects of dual eligible status and LIS status. It should be noted that by default SAS models the event of 0 or Non-compliance.

Table 4- Covariate specific rates of factors included in multivariate modeling.

Model Covariate	Frequency (%) n=250,906
LIS Yes	23.36
D-SNP Yes	13.98
Age 65+	91.67
Gender Female	57.84
HCC 5+	14.04

Table 4 provides statistics on the proportion for some of the covariates included in the multivariate modeling. Certain covariates included in the model have been excluded from table 4 and related outputs (Tables 5 and 6). Additionally, it should be noted that specific member factors which may be related to the outcome have not been included because data cannot be reliably identified. These factors include, but are not limited to, spoken and written language, access to providers, access to transportation, as well as other similar member factors. These factors could not be evaluated or controlled for in the models and may present various levels of confounding.

Table 5 provides the odds ratio for non-compliance rates for specific measures across several factors. Odds Ratios are only interpreted when the covariates were found to be statistically significant at $p \leq 0.05$. Note that, within each category, the effect of other factors has been controlled for (that is, reporting on individual covariates assumes that all other covariates in the model are held constant.) An odds ratio of 1.44 for dual eligibles under the breast cancer screening category means that dual eligibles are 44 percent more likely to be non-compliant for this screening as compared to non-dual eligibles after controlling for other factors. Table 6 includes similar results comparing beneficiaries who are in the LIS program as compared to those who do not.

While performance varies for specific measures, one general trend suggested by these data is that dual eligible or LIS beneficiaries have lower compliance scores than other beneficiaries when it comes to general preventive screenings, have average or higher scores with regard to receiving care for existing diseases (such as diabetes), and have lower scores in measures of medication adherence. Please see the appendix for further discussion regarding the statistical modeling methods.

Table 5 – CY2015 logistic regression of *Dual Eligible Model* - Odds Ratio for Health Net HMO contracts for clinical measures.

Star Measure	Odds Ratio			
	Dual Eligible	HCC 5+	Female	Age Less than 65
Breast Cancer Screening	1.444	1.367	N/A	1.051
Colorectal Cancer Screening	1.232	0.786	1.019	1.224
Cardiovascular Care – Cholesterol Screening	1.529	0.884	1.185	1.273
Diabetes Care - Cholesterol Screening	1.261	0.916	0.934	1.43
COA for SNP mbrs - Medication Review	0.857	0.755	1.146	N/A
COA for SNP mbrs - Functional Status Assessment	0.875	0.759	0.864	N/A
COA for SNP mbrs - Pain Screening	0.961	0.799	0.864	N/A
Osteoporosis Mgmt. in Women who had a Fracture	1.196	1.097	N/A	N/A
Diabetes Care - Eye Exam	1.068	0.903	0.853	1.621
Diabetes Care - Kidney Disease Monitoring	0.769	0.38	0.937	1.558
Diabetes Care - Blood Sugar Controlled	1.036	0.866	0.944	1.418
Diabetes Care - Cholesterol Controlled	1.001	0.77	1.233	1.352
Rheumatoid Arthritis Management	1.327	1.471	0.736	0.692
Plan All Cause Readmission*	0.966	0.225	1.001	N/A
High Risk Medication*	1.051	0.533	0.629	N/A
Diabetes Treatment	0.875	1.654	1.05	1.105
Medication Adherence - Oral Diabetes Medications	1.06	1.192	1.069	1.246
Medication Adherence for Hypertension (ACEI or ARB)	1.245	1.519	0.955	1.343
Medication Adherence for Cholesterol (Statins)	1.348	1.239	1.15	1.216

*Inverted Measure - Lower Rate indicates higher performance

N/A - Not applicable for inclusion in the model based on measures specifications. For example Breast Cancer Screening applies to women only; as a result gender cannot be modeled.

Green shading indicates predictor is statistically significant ($p \leq 0.05$) given the other predictor variables are in the model

Note: The Plan all Cause readmission measure results being analyzed are not case mixed.

Table 6 – CY2015 logistic regression of LIS Model - Odds Ratio for Health Net contracts for Clinical measures.

Star Measure	Odds Ratio			
	LIS	HCC 5+	Female	Age Less than 65
Breast Cancer Screening	1.507	1.362	N/A	1.011
Colorectal Cancer Screening	1.277	0.781	1.001	1.179
Cardiovascular Care - Cholesterol Screening	1.255	0.977	1.155	1.3
Diabetes Care - Cholesterol Screening	1.187	1	0.937	1.337
Osteoporosis Mgmt. in Women who had a Fracture	1.167	1.118	N/A	N/A
Diabetes Care - Eye Exam	1.107	0.909	0.832	1.593
Diabetes Care - Kidney Disease Monitoring	0.757	0.42	0.965	1.581
Diabetes Care - Blood Sugar Controlled	1.066	0.872	0.939	1.361
Diabetes Care - Cholesterol Controlled	1.036	0.788	1.221	1.322
Rheumatoid Arthritis Management	1.206	1.427	0.76	0.744
Plan All Cause Readmission*	0.846	0.224	1.061	N/A
High Risk Medication*	0.942	0.534	0.59	N/A
Diabetes Treatment	0.942	1.709	1.068	1.056
Medication Adherence - Oral Diabetes Medications	0.994	1.2	1.074	1.281
Medication Adherence for Hypertension (ACEI or ARB)	1.165	1.562	0.952	1.328
Medication Adherence for Cholesterol (Statins)	1.218	1.192	1.112	1.222

*Inverted Measure - Lower Rate indicates higher performance

N/A - Not applicable for inclusion in the model based on measures specifications. For example Breast Cancer Screening applies to women only; as a result gender cannot be modeled.

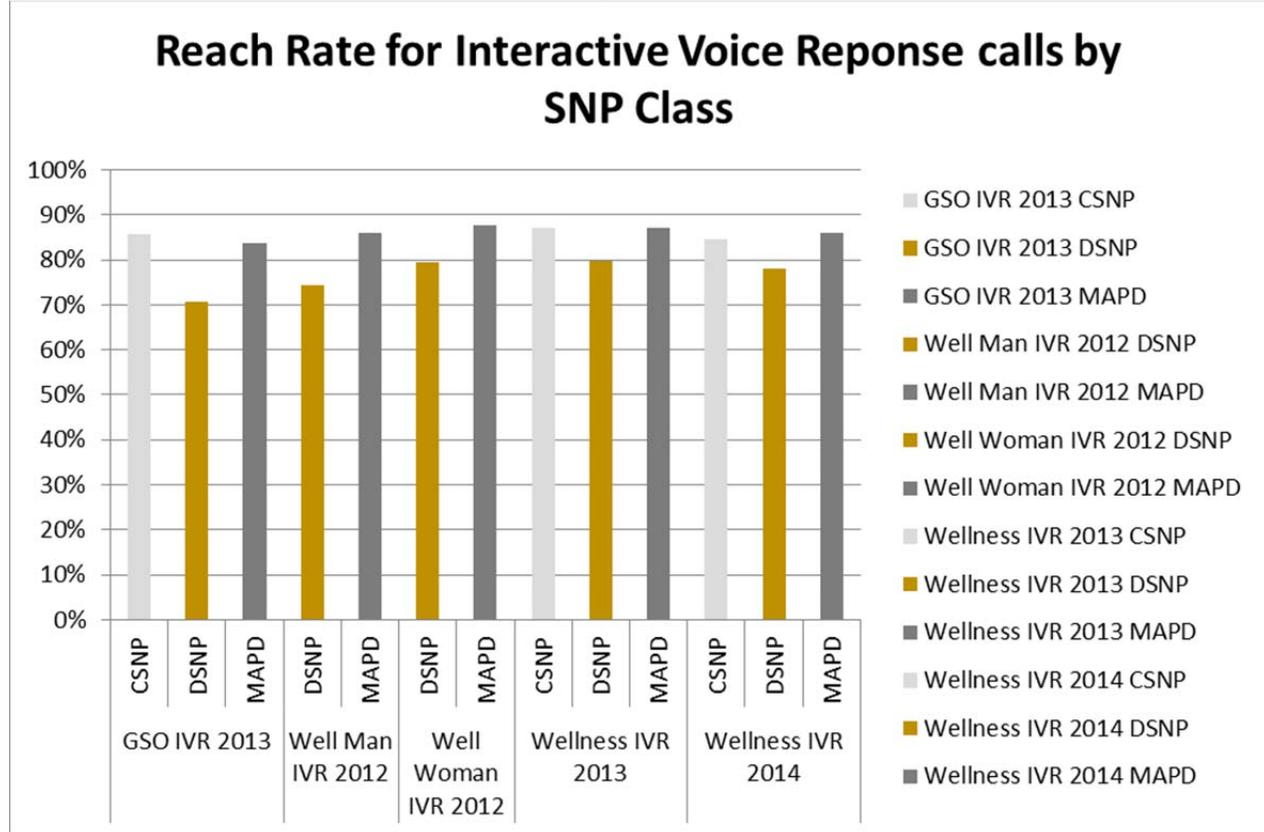
Green shading indicates predictor is statistically significant ($p \leq 0.05$) given the other predictor variables are in the model

Note: The Plan all Cause readmission measure results being analyzed are not case mixed.

Contacting Members

As part of our member education and wellness strategies, Health Net often contacts members through phone calls. Data resulting from these campaigns consistently demonstrates that it is more likely that D-SNP enrollees cannot be contacted (Chart 5). Although Health Net continues to exert significant efforts to make such contact, and is continually developing new ways to contact members who cannot be contacted through traditional means, contacting those members remains a greater challenge than for other beneficiaries. This suggests the possibility that one of the factors driving lower rates for certain measures, particularly those related to screenings and follow-up care, may be the unique difficulties health plans face in contacting dual eligible or LIS members, and the ability to contact these members may not be at the same level as other beneficiaries.

Chart 5 – Reach rate for 2013 Interactive Voice Response (IVR) SNP as compared to Non-SNP members for the Health Net’s CA HMO -H0562 Contract only



Conclusion

As noted above, it appears that a number of factors may be contributing to lower Star Ratings performance for plans with a relatively high share of D-SNP or LIS beneficiaries. After controlling for factors such as age, number of HCCs, and gender, the data suggests that one of the key contributors seems to be the socio-economic status of the beneficiary. Our analysis of the zip code level poverty information discussed above appears to demonstrate this, and may be worthy of additional consideration at an even more detailed level such as census tract.

In addition, although Star Ratings are on average lower for health plans with D-SNP beneficiaries, this is not distributed equally across all types of measures. Rather, there seem to be certain types of measures in which dual eligible or LIS status makes a significant difference.

We believe the analysis of our data, along with that of others, provides strong support for the need for further study by CMS. This is an extremely important issue. Star Ratings is an important program and can provide incentives for quality. However, at the same time the program could bring about unintended consequences if the program’s design generates systematically lower scores for plans that enroll a significant number of dual eligible and LIS beneficiaries

Appendix: Discussion of Performance on Specific Measures

Select covariates were included in the model to account for differences in region and product and have not been included in interpretation of outcomes.

Dual Eligible Model

Note: by default SAS models the event of 0 or Non-compliant.

Outcome: Compliance Status (Compliant=1, Non-Compliant=0)

Note: by default SAS models the event of 0 or Non-compliant.

Covariates: Dual eligible status (Yes=1 and No=0), member HCC Count 5 or more (Yes=1 and No=0), gender female (Yes=1 and No=0), age less than 65 (Yes=1 and No=0), AZ HMO Medicare Contract – H0351 (Yes=1 and No=0), CA HMO Medicare Contract – H0562 (Yes=1 and No=0), OR HMO Medicare contract – H6815 (Yes=1 and No=0).

LIS Model

Outcome: Compliance Status (Compliant=1, Non-Compliant=0)

Note: by default SAS models the event of 0 or Non-compliant.

Covariates: Member receives LIS (Yes=1 and No=0), member HCC Count 5 or more (Yes=1 and No=0), gender female (Yes=1 and No=0), age less than 65 (Yes=1 and No=0), AZ HMO Medicare Contract – H0351 (Yes=1 and No=0), CA HMO Medicare Contract – H0562 (Yes=1 and No=0), CA PPO Medicare Contract – H5439 (Yes=1 and No=0), OR PPO Medicare Contract – H5520 (Yes=1 and No=0), OR HMO Medicare contract – H6815 (Yes=1 and No=0).

Breast Cancer Screening

Dual Eligible Model

Dual eligible members were 44% more likely to be non-compliant. Members with 5+ HCCs were 37% more likely to be non-compliant.

LIS Model

LIS members were 51% more likely to be non-compliant. Members with 5+ HCCs were 36% more likely to be non-compliant.

Colorectal Cancer Screening

Dual Eligible Model

Dual eligible members were 23% more likely to be non-compliant. Members with 5+ HCCs were 27% more likely to be compliant. Members less than 65 years old were 22% more likely to be non-compliant.

LIS Model

LIS members were 28% more likely to be non-compliant. Members with 5+ HCCs were 28% more likely to be compliant. Members less than 65 years old were 18% more likely to be non-compliant.

Cardiovascular Care - Cholesterol Screening

Dual Eligible Model

Dual eligible members were 53% more likely to be non-compliant. Female members were 19% more likely to be non-compliant. Members less than 65 years old were 27% more likely to be non-compliant.

LIS Model

LIS members were 26% more likely to be non-compliant. Female members were 16% more likely to be non-compliant. Members less than 65 years old were 30% more likely to be non-compliant

Diabetes Care - Cholesterol Screening

Dual Eligible Model

Dual eligible members were 26% more likely to be non-compliant. Members less than 65 years old were 43% more likely to be non-compliant.

LIS Model

LIS members were 19% more likely to be non-compliant. Members less than 65 years old were 34% more likely to be non-compliant.

COA for SNP mbrs - Medication Review

Dual Eligible Model

No significant differences were identified.

COA for SNP mbrs - Functional Status Assessment

Dual Eligible Model

Dual eligible members were 14% more likely to be compliant. Members with 5+ HCCs were 32% more likely to be compliant. Female members were 16% more likely to be compliant.

COA for SNP mbrs - Pain Screening

Dual Eligible Model

Members with 5+ HCCs were 25% more likely to be compliant. Female members were 16% more likely to be compliant.

Osteoporosis Mgmt. in Women who had a Fracture

Dual Eligible Model

No significant differences were identified.

LIS Model

No significant differences were identified.

Diabetes Care - Eye Exam

Dual Eligible Model

Dual eligible members were 7% more likely to be non-compliant. Members with 5+ HCCs were 11% more likely to be compliant. Members less than 65 years old were 62% more likely to be non-compliant.

LIS Model

LIS members were 11% more likely to be non-compliant. Members with 5+ HCCs were 10% more likely to be compliant. Female members were 20% more likely to be compliant. Members less than 65 years old were 59% more likely to be non-compliant.

Diabetes Care - Kidney Disease Monitoring

Dual Eligible Model

Dual eligible members were 30% more likely to be compliant. Members with 5+ HCCs were 2.6 times more likely to be compliant. Members less than 65 years old were 56% more likely to be non-compliant.

LIS Model

LIS members were 32% more likely to be compliant. Members with 5+ HCCs were 2.4 more likely to be compliant. Members less than 65 years old were 58% more likely to be non-compliant.

Diabetes Care - Blood Sugar Controlled

Dual Eligible Model

Members with 5+ HCCs were 15% more likely to be compliant. Female members were 6% more likely to be compliant. Members less than 65 years old were 42% more likely to be non-compliant.

LIS Model

LIS members were 7% more likely to be non-compliant. Members with 5+ HCCs were 15% more likely to be compliant. Female members were 6% more likely to be compliant. Members less than 65 years old were 36% more likely to be non-compliant.

Diabetes Care - Cholesterol Controlled

Dual Eligible Model

Members with 5+ HCCs were 30% more likely to be compliant. Female members were 23% more likely to be non-compliant. Members less than 65 years old were 35% more likely to be non-compliant.

LIS Model

Members with 5+ HCCs were 27% more likely to be compliant. Female members were 22% more likely to be compliant. Members less than 65 years old were 32% more likely to be compliant.

Rheumatoid Arthritis Management

Dual Eligible Model

Dual eligible members were 33% more likely to be non-compliant. Members with 5+ HCCs were 47% more likely to be non-compliant. Female members were 36% more likely to be compliant. Members less than 65 years old were 45% more likely to be compliant.

LIS Model

Members with 5+ HCCs were 43% more likely to be non-compliant. Female members were 32% more likely to be compliant. Members less than 65 years old were 35% more likely to be compliant.

Plan All Cause Readmission

Dual Eligible Model

Members with 5+ HCCs were 4.4 times more likely to be non-compliant.

LIS Model

LIS members were 18% more likely to be non-compliant. Members with 5+ HCCs were 4.5 more likely to be non-compliant.

High Risk Medication

Dual Eligible Model

Dual eligible members were 5% more likely to be compliant. Members with 5+ HCCs were 88% more likely to be non-compliant. Female members were 59% more likely to be non-compliant.

LIS Model

LIS members were 6% more likely to be non-compliant. Members with 5+ HCCs were 87% more likely to be non-compliant. Female members were 69% more likely to be non-compliant.

Diabetes Treatment

Dual Eligible Model

Dual eligible members were 14% more likely to be compliant. Members with 5+ HCCs were 65% more likely to be non-compliant. Members less than 65 years old were 11% more likely to be non-compliant.

LIS Model

Members with 5+ HCCs were 71% more likely to be non-compliant. Female members were 7% more likely to be non-compliant.

Medication Adherence - Oral Diabetes Medications

Dual Eligible Model

Members with 5+ HCCs were 19% more likely to be non-compliant. Female members were 7% more likely to be non-compliant. Members less than 65 years old were 25% more likely to be non-compliant.

LIS Model

Members with 5+ HCCs were 20% more likely to be non-compliant. Female members were 7% more likely to be non-compliant. Members less than 65 years old were 28% more likely to be non-compliant.

Medication Adherence for Hypertension (ACEI or ARB)

Dual Eligible Model

Dual eligible members were 25% more likely to be non-compliant. Members with 5+ HCCs were 52% more likely to be non-compliant. Female members were 15% more likely to be compliant. Members less than 65 years old were 34% more likely to be non-compliant.

LIS Model

LIS members were 17% more likely to be non-compliant. Members with 5+ HCCs were 56% more likely to be non-compliant. Female members were 5% more likely to be compliant. Members less than 65 years old were 33% more likely to be compliant.

Medication Adherence for Cholesterol (Statins)

Dual Eligible Model

Dual eligible members were 35% more likely to be non-compliant. Members with 5+ HCCs were 24% more likely to be non-compliant. Female members were 15% more likely to be non-compliant. Members less than 65 years old were 22% more likely to be compliant.

LIS Model

LIS members were 22% more likely to be non-compliant. Members with 5+ HCCs were 19% more likely to be non-compliant. Female members were 11% more likely to be non-compliant. Members less than 65 years old were 22% more likely to be compliant.

Data Sources

The following publicly available data sources, in conjunction with certain data held by Health Net, were utilized in this analysis.

CY2015 Plan Specific Star Data:

<http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2015-Part-C-and-D-Medicare-Star-Ratings-Data-v10-09-2014.zip>

CMS Plan Enrollment:

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Items/Enrollment-by-Contract-2013-12.html>

CMS Plan SNP Enrollment:

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2013-12.html>

CMS Plan LIS Enrollment:

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/LIS-Enrollment-by-Plan-Items/2013-Low-Income-Subsidy-Enrollment-by-Plan.html>