November 3, 2014

Marilyn Tavenner, RN, MHA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Washington, DC 20201

Submitted electronically 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 Administrator Tavenner:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to submit data and comments in response to the Request for Information on differences between dual-eligible and non-dual-eligible enrollees regarding plan performance on quality measures and the star ratings system.

ACHP is a national leadership organization representing community-based and regional health issuers and provider organizations. ACHP's member health plans provide coverage and care for more than 18 million Americans. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems; most cover substantial numbers of Medicare Advantage (MA) enrollees. Seven of the eleven 5-star rated MA plans are offered by ACHP members. Our member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

Introduction

The Center for Medicare & Medicaid Services (CMS) requested analyses and research that demonstrate that dual status *causes* lower MA and Part D quality measure scores or 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.

We applaud CMS' efforts to continue to make enhancements to the MA and Part D star ratings program. And we greatly appreciate that CMS is responsive to the concerns raised by Dual Special Needs Plans (DSNPs) and others about dual-eligible enrollment and the star ratings system. While the RFI does not pose questions on policy options, ACHP believes DSNPs and other plans with high enrollment of dual eligibles face significant challenges in caring for populations that are both clinically complex and affected by socioeconomic factors – not the least of which are communications and transportation problems that affect their ability to access care and the plan's ability to provide care. CMS should carefully consider modifications that would ensure that DSNPs are not at a disadvantage in achieving high star ratings, and do so in a way that would not compromise the overall goals of the star rating system.

The analysis that follows, which ACHP has done using publicly available information, does not show a consistent relationship between DSNP beneficiary characteristics and plan performance. In fact, on many star ratings measures, a DSNP contract was able to achieve 5-star performance. But this does not deny the possibility that individual measures may pose specific problems for the DSNP population. One option for consideration is a review of measures to make sure the denominator of each measure carefully reflects the recommended standard of care for the DSNP population. Another is to evaluate the appropriateness of measures for the SNP population, and potentially to develop a limited number of SNP-specific measures (as CMS has done with the HEDIS Care for Older Adults and SNP Care Management measures), although we caution that the relevance of clinical measures should be determined by clinical science and not by the type of plan in which a beneficiary is enrolled. Still another option is to consider DSNPs with particularly challenging populations – for example, large numbers of enrollees who have complex health and social problems, perhaps involving behavioral health needs – as outliers so that they are excluded from reporting on certain measures that may not be applicable. Finally, while CMS develops longer-term solutions, CMS should consider temporary payment of the quality incentive bonus for DSNPs at the 3.5 star level for 2016 and 2017.

We believe that CMS should consider policy options such as these to address the concerns of SNP sponsors, and that this is a better approach than risk-adjusting quality measures for socioeconomic status. Such adjustment is appropriate when there is a clear external factor that affects performance on a measure – for example, adjusting for age on mortality measures. But risk adjustment is not appropriate when it "risk adjusts away" problems of high quality care that the health plan and its delivery system partners are expected to deliver, regardless of the population. In that case, variations in outcomes by income, race or other factors included as adjustments to the measures are hidden, even though these variations may account for significant differences in the treatment of the patient across different plans or providers.

ACHP offers the data analysis below in response to the RFI. Because many plans may respond to the RFI with their own plan-specific data, ACHP believes that looking at <u>all available measures</u> (not just ones where dual-eligible SNP plans lagged or exceeded other MA plans) across <u>all plans</u> for insight into this request may add an additional perspective to CMS' efforts. In particular, we wanted to explore whether patterns in the types of measures in which dual-eligible SNP plans lagged or exceeded performance compared to the rest of MA could hint at drivers (causes) of these differences and consequently allow for more effective measure changes. We hope our analyses are useful in helping CMS consider these issues.

Data and Methods

To conduct this analysis we relied on publicly available CMS data files found in the following locations:

2013 Medicare HEDIS: http://cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-HEDIS-Public-Use-Files.html

2013 Medicare SNP HEDIS: http://cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/SNP-HEDIS-Public-Use-Files.html

2014 Star Ratings: http://cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html

This information was loaded into a MS Access Database and cross-walked with CMS plan information files and February 2012 enrollment files found here: http://cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html.

Findings

ACHP examined the performance of MA plans on various HEDIS measures *versus* Dual-eligible Special Needs Plans (DSNPs). This data is limited to some administrative HEDIS measures.[1] The comparison, presented in **Table 1** below, is not perfect because the MA average necessarily includes SNP members as well, thus the differences indicated below may be slightly larger if the MA average only included non-SNP beneficiaries. With that caveat, several points emerged:

- Many top-performing DSNPs scored a perfect 100 percent on HEDIS measures; for those measures included in the star ratings, the top DSNP performer achieved 5-star performance with the exception of high-risk medication management.
- There was not a clear difference in HEDIS performance between MA plans broadly and DSNPs, with DSNPs having higher performance on some measures and lower performance on others.
- DSNP plans tended to have better performance in measures that required medication adherence or medication monitoring. This could be a result of lower cost-sharing on prescription medications and the model of care in many DSNP programs.
- Large performance gaps exist between top-performing DSNP plans and average DSNP plan performance on almost all the HEDIS measures available for this analysis; among several possible explanations, these differences could be related to the care model or DSNP population characteristics.

[1] Some HEDIS measures use a hybrid methodology that requires chart reviews in addition to claims data. These chart reviews are done with statistical significance at the contract level (not plan level) in mind.

Table 1: Performance of DSNP Plans Compared to "All MA Averages" on the Set of Publicly Reported HEDIS Measures in Publicly Available CMS Data Files

2013 HEDIS Measure Name	All Medicare Average	DSNP Average	DSNP Max	All Medicare/ DSNP Difference	DSNP Max/ Average Difference
Antidepressant Medication Acute Phase Treatment	70.4	62.4	91.7	8.0	29.3
Antidepressant Medication Continuation Phase Treatment	58.2	49.0	83.3	9.2	34.4
Colorectal Cancer Screening	61.3	60.3	90.4	1.0	30.1
Controlling Blood Pressure	62.2	59.3	88.8	2.9	29.5
Glaucoma Screening	68.5	69.9	95.3	-1.4	25.4
Management of COPD Bronchodilator	79.2	83.7	100.0	-4.5	16.3
Management of COPD Systemic Corticosteroids	69.1	67.1	89.4	2.0	22.2
Mental Illness Hospitalization 30 Day Follow-up	57.3	53.4	100.0	3.9	46.6
Mental Illness Hospitalization 7 Day Follow-up	37.6	35.6	100.0	2.0	64.4
Monitoring of Long-Term Meds ACE Inhibitors	91.9	92.8	100.0	-1.0	7.2
Monitoring of Long-Term Meds Anticonvulsants	66.2	68.4	93.1	-2.2	24.7
Monitoring of Long-Term Meds Combined Rate	91.4	91.8	100.0	-0.3	8.2
Monitoring of Long-Term Meds Digoxin	94.0	95.5	100.0	-1.4	4.5
Monitoring of Long-Term Meds Diuretics	92.2	93.1	100.0	-0.9	6.9
Osteoporosis Management	22.8	26.6	92.3	-3.8	65.6
Persistence of Beta-Blocker Treatment after Heart Attack	88.8	89.7	100.0	-1.0	10.3
Potentially Harmful Rx for Renal Failure (Reversed)	89.1	81.8	95.8	7.4	14.1
Potentially Harmful Rx Interactions (Reversed)	80.0	74.5	89.3	5.6	14.8
Potentially Harmful Rxs for Dementia (Reversed)	75.4	69.3	90.1	6.1	20.8
Potentially Harmful Rxs for Falls (Reversed)	84.6	81.3	93.8	3.3	12.4
Use of One High-Risk Medications (Reversed)	79.0	73.1	90.1	6.0	17.0
Use of Spirometry to Diagnose COPD	36.0	33.3	77.2	2.7	43.9
Use of Two or More High-Risk Medications (Reversed)	93.4	91.2	98.3	2.2	7.0

Our second set of analyses focused on contract-level star ratings data, which is less specific to DSNP plans, but included results on a larger number of star rating measures. We examined star ratings performance in DSNP contracts, which we defined as contracts in which greater than 75 percent of members were in DSNP plans. This was compared to contracts that had no SNP members.[2] We omitted measures from the CAHPS survey that are already case-mix adjusted, the risk-adjusted readmission measure, and the HOS physician and mental health improvement measures. This analysis included the 2014 star ratings from 63 DSNP contracts and 272 non-SNP contracts.

Table 2: Overall Star Ratings Comparison of DSNP and non-SNP Contracts

2014 Star Rating Overall	DSNP Contracts Average Star Rating (Rounded)	Non-SNP Contracts Average Star Rating (Rounded)	Difference – DSNP vs. Non-SNP (Rounded)
Overall Star Rating (Part C & D)	3.3	3.8	0.5

On overall star ratings, DSNP contracts were about a half-star lower on the 2014 star ratings (**Table 2**). Part of this is driven by performance measure differences on individual measures illustrated in Table 1. However, part of the difference can also be explained by the fact that a larger portion of non-SNP contracts obtain overall performance that is high enough to qualify for an iFactor bonus,[3] raising the average performance of those plans above the average of the individual, weighted measures. An issue for further consideration is the appropriateness of some CAHPS questions to the DSNP population.

Table 3: Individual Star Ratings Comparisons between DSNP and non-SNP Contracts on Adherence Measures[4]

2014 Star Rating Measures Requiring Adherence	DSNP Contracts Average Star Rating (Rounded)	Non-SNP Contracts Average Star Rating (Rounded)	Star Rating Obtained by Top-Performing DSNP Contract	Difference – DSNP vs. Non-SNP (Rounded)
Osteoporosis Management	1.60	1.92	3	0.32
Controlling Blood Pressure	3.57	3.57	5	0.01
Diabetes – Blood Sugar Controlled	2.80	3.48	5	0.67
Diabetes – Cholesterol Controlled	2.87	3.68	5	0.81
Medication Adherence for Diabetes	3.37	4.08	5	0.72
Rheumatoid Arthritis Management	2.91	4.01	5	1.10
Taking Cholesterol Medication	3.27	3.94	5	0.67
Taking Oral Diabetes Medication	3.13	2.99	5	-0.14
Average	2.94	3.46	4.75	0.52

Table 3 looks at star rating measures that require some patient adherence. Here the star ratings performance difference is the same as the difference across all measures (Table 2) – about a half star. However, for two measures there is little or no performance disadvantage for DSNP contracts. The largest gap was in Rheumatoid Arthritis Management. On all but one measure (Osteoporosis Management), there is a DSNP contract at the 5-star level.

[2] Based on February 2012 enrollment, which aligns with 2013 HEDIS and 2014 star ratings.
[3] This analysis was not performed as a part of this RFI, but could be added upon request.
[4] Adherence measures are not defined by CMS, but rather represent a set of measures where some action outside of the provider office is required by the patient in order to qualify as a numerator in the measure specifications.

Table 4: Individual Star Ratings Comparisons between DSNP and non-SNP Contracts on Visit Requirement Measures[5]

2014 Star Rating Measures Requiring a Visit	DSNP Contracts Average Star Rating (Rounded)	Non-SNP Contracts Average Star Rating (Rounded)	Star Rating Obtained by Top-Performing DSNP Contract	Difference – DSNP vs. Non-SNP (Rounded)
Improving Bladder Control	2.45	2.27	3	-0.18
Adult BMI Assessment	3.76	3.65	5	-0.11
Annual Flu Vaccine	2.90	3.74	5	0.85
Breast Cancer Screening	2.70	3.40	5	0.70
Cardiovascular – Cholesterol Screening	3.57	4.35	5	0.78
Colorectal Cancer Screening	3.43	4.08	5	0.64
Diabetes - Cholesterol Screening	3.20	3.87	4	0.67
Diabetes – Eye Exam	4.17	3.94	5	-0.24
Diabetes – Kidney Disease Monitoring	4.46	4.48	5	0.03
High Risk Medication	2.74	3.80	5	1.06
Monitoring Physical Activity	2.60	2.32	5	-0.28
Reducing the Risk of Falling	4.61	2.95	5	-1.66
Blood Pressure Medication for Diabetes	3.13	4.13	5	1.00
Average	3.36	3.61	4.77	0.25

Table 4 looks at star rating measures requiring a visit (but not adherence). For these measures the average star performance gap is smaller than on measures that require adherence. On five of these measures, DSNP contracts outperformed non-SNP contracts; many of these were measures from the HOS survey. Two measures had an advantage of more than one star for non-SNP contracts. Both of these measures are tied to medication reconciliation. Anecdotally, members with more medications have been more difficult for plans to bring into compliance with the high-risk medication management measure. On all but two of these measures, the top-performing DSNP contract was able to achieve 5-star performance.

[5] Visit requirement measures are not defined by CMS, but rather represent a set of measures for which the requirements to be counted in the numerator of the measure involve seeing a provider and that provider performing the required service, with no further action required by the member.

Table 5: Individual Star Ratings Comparisons between DSNP and non-SNP Contracts on Health Plan Administration Measures[6]

2014 Star Rating Measures Based on Health Plan Administration	DSNP Contracts Average Star Rating (Rounded)	Non-SNP Contracts Average Star Rating (Rounded)	Star Rating Obtained by Top-Performing DSNP Contract	Difference – DSNP vs. Non (Rounded)
Health Plan Makes Timely Decisions about Appeals	3.69	4.24	5	0.54
Appeals Auto–Forward	3.08	3.43	5	0.34
Appeals Upheld	2.50	3.51	5	1.01
Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Drug Plan	2.47	3.41	5	0.94
Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Health Plan	4.22	4.57	5	0.35
Beneficiary Access and Performance Problems (Audits)	3.28	3.51	5	0.23
Beneficiary Access and Performance Problems (Audits)	3.28	3.44	5	0.16
Complaints about the Drug Plan	3.67	3.07	5	-0.61
Complaints about the Health Plan (per 1000)	3.67	3.09	5	-0.59
Members Choosing to Leave the Drug Plan (lower = better)	4.02	3.78	5	-0.24
Members Choosing to Leave the Health Plan (lower = better)	4.02	3.81	5	-0.21
MPF Price Accuracy	3.79	3.88	4	0.09
Reviewing Appeals Decisions	2.44	3.33	5	0.89
Average	3.40	3.62	4.92	0.22

Table 5 looks at star rating measures for health plan administration. One would expect that these measures would not show performance differences driven by the characteristics of the population served. Nonetheless, there was a 0.22 star advantage on average for non-SNP contracts. DSNP contracts tended to perform better on measures related to members choosing to leave or members complaining. One driver of disenrollment in non-SNP MA plans is gaining Medicaid eligibility, so the results on disenrollment are not surprising. Additionally, if we exclude the disenrollment measure and only count the measures that are the same for Part C and D once, the overall gap between DSNP contracts and non-SNP contracts increases to around 0.4 stars, which is close to the overall star-ratings gap.

One would expect to see the greatest differences between DSNPs and non-SNPs in measures that are more population dependent (*e.g.,* adherence measures) and the least differences in measures that have less to do with the characteristics of the population served but are more in the control of the plan (*e.g.,* health plan administration measures). This analysis of the 2014 star ratings data does not support this hypothesis.

[6] Health Plan Administration measures are not defined by CMS, but rather represent a set of measures for which there are no requirements for action by a provider or the member. Performance on these measures is in the control of health plan administration, reflecting their adherence to standard processes.

Observations

ACHP has presented this analysis in the belief that looking at all available measures across all plans – not just measures for which dual-eligible SNPs lagged or exceeded other MA plans – might provide insights that would help CMS consider important policy questions related to health plan performance and the goals of the star rating system.

Adjustment of measures is appropriate when there is a clear external factor that causes an inherent disadvantage for performance on a measure. Adjusting for age in mortality measures is an example. While there are several hypotheses that could explain lower DSNP performance on some measures (*e.g.,* lower educational/literacy levels make communication about the importance of screenings difficult), there are other possibilities that could explain the lower performance without attribution to population differences (*e.g.,* internal plan processes) or would tend to refute those hypotheses (*e.g.,* if it is difficult to communicate the importance of screening, that should also be true for communicating the need to reduce trip hazards). For these reasons it is difficult, using publicly available information, to establish a relationship between SNP beneficiary characteristics and plan performance.

Additionally, we observed that on almost all star ratings measures, a DSNP contract was able to obtain 5-star performance. This would support the conclusion that either not all DSNP plans have populations with characteristics that make obtaining high performance difficult, or those plans were able to undertake efforts that helped them achieve the 5-star level even with their more complex population.

This analysis does not deny the possibility that individual, specific measures may pose specific problems for the DSNP population. These causes may be different for each measure and reflect different characteristics of the DSNP population. In this case, the proper approach may be to make sure the denominator of each measure is specifically tailored to the recommended standard of care for the DSNP population. Additionally, CMS has added new SNP-only measures in recent years; this approach also supports the unique care needs of the SNP population. Finally, perhaps some DSNP plans with certain characteristics (*e.g.,* majority under 65 or a high proportion of cognitive impairments) may be excluded from reporting some measures as part of their star ratings total.

Conclusion

Analyzing data at the plan level (where available) and the contract level, there was not a clear performance advantage for DSNP plans *versus* non-SNP plans and contracts on HEDIS and star rating measures. On average, DSNP performance does tend to be lower, but on some measures performance is higher, and on many measures DSNP plans are among the highest performing plans in the country. The variability of relative performance among measures, along with the lack of pattern in differences by type of measure, points away from a single or common set of population characteristics driving these performance differences. Nonetheless, some individual measures may need closer examination of their denominators to make sure they reflect the standard of care for all members they measure, and more extreme DSNP populations may need additional flexibility in their reporting.

While analysis of the data does not show a causal or consistent relationship between DSNP beneficiary characteristics and plan performance, ACHP believes DSNPs and other plans with high enrollment of dual eligibles face significant challenges in caring for populations that are both clinically complex and affected by socioeconomic factors. We hope that CMS will strive for a careful balance that, on the one hand,

ensures that DSNPs are not at a disadvantage in achieving high star ratings and, on the other hand, maintains the integrity and advances the overall goals of the star rating system.

Thank you for consideration of that data we have presented. If there are any questions or CMS staff requires additional information, please contact Howard Shapiro, ACHP Director of Public Policy, at hshapiro@achp.org.

Sincerely,

Patricia Smith
President and CEO