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SUBMITTED ELECTRONICALLY TO PartCandDStarRatings@cms.hhs.gov

PUERTO RICO MEDICARE COALITION FOR FAIRNESS

Response to the CMS 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"

Contents of this Report in Response to the CMS RFI

I. Who are we?

Puerto Rico is the US jurisdiction with the highest MA penetration at 74% of all Medicare. This response presents the perspective of a multi-stakeholder group of local healthcare leadership committed to the fair development of quality and accessible healthcare for over 740,000 beneficiaries in the Medicare program in PR. There are more Medicare beneficiaries living in Puerto Rico than in 28 US jurisdictions, including 25 states.

We write on behalf of the **Puerto Rico Medicare Coalition for Fairness** represented in these comments by the following signing associations:

- **Medicaid and Medicare Advantage Association of Puerto Rico, Inc. (MMAPA)**, which is composed of the main health plans on the island that combined serve over 500,000 Medicare Advantage (MA) members;
- **The Puerto Rico Community Pharmacies Association**, representing over 700 community pharmacies on the island which provide services for more than 80% of the MAPD prescription drug utilization in PR;
- **The Puerto Rico Hospital Association**, which members provide services to the over 3.6 million residents of the island of Puerto Rico;
- **The Puerto Rico IPA Association**, representing primary care physician groups on the island that mainly work with over 1.6 million Medicaid beneficiaries;
- **Puerto Rico Physical Medicine and Rehabilitation Association**
- **The Puerto Rico Chamber of Commerce**

The topic and general recommendation included in this document is also part of the ***PR Medicare Coalition for Fairness Memorandum of Understanding*** signed August 28, 2014. (***See Appendix 1***)

For more information about the Coalition, please visit www.prmedicarecoalitionforfairness.org.

II. Objectives and Structure of this Response

As instructed in the RFI document and further explained by CMS officials, our MA health plans in Puerto Rico prepared and are submitting intra-plan specific analysis about the differences in rating between "Duals and Non-Dual" populations. The objective of this response is to summarize the general observations, conclusions and recommendations for the scenario of Puerto Rico, as discussed among the plans in ***MMAPA*** (www.mmapapr.com) and the ***PR Medicare Coalition for Fairness*** leaders (www.prmedicarecoalitionforfairness.org). Even when detailed data was not aggregated across plans, the signatories have concluded that our intra-plan analysis is supportive of the conclusions and recommendations presented herein.

III. Acronyms and Key Definitions

• **Dual,** beneficiaries in D-SNPs	• **OOPC,** out of pocket costs for beneficiaries
• **Non-Dual,** beneficiaries MAPDs	• **FPL**, Federal Poverty Level
• **EGWP,** beneficiaries in Employer Group Waiver Plans	• **Medicare Platino,** integrated Medicare-Medicaid program in the island contracted by DSNPs with Commonwealth of PR
• **D-SNP,** CMS special needs plan for dual - beneficiaries with Medicare and Medicaid	• **SES,** Socio-economic status
• **LIS,** Part D Low Income Subsidy	• **SSI,** Supplemental Security Income

IV. Executive Summary

In the case of Puerto Rico (PR), the Dual/Non-Dual comparison is not a proxy of income and socioeconomic status (SES) as it may be represented in similar analysis for the rest of the jurisdictions. Key particularities in the island include differing income eligibility standards for Medicaid (87% FPL in PR), and benefit exclusions defined by Congress like the Part D Low Income Subsidy and the Supplemental Security Income (SSI). Inevitably, establishing a SES risk factor adjustment methodology should take into account beneficiary income, benefits and education. In the case of Territories, this includes the need to account for statutory benefit differences, like LIS, which are evidently impacting critical measures and negatively impacting these jurisdictions unfairly.

Notwithstanding, PR MA plans serving dual status patients had significantly higher star ratings than non-dual plans, demonstrating that higher quality performance in MA and Part D plans serving low income beneficiaries can be obtained. This higher quality performance level for the dual program has been reached using the same provider network but with significant adjustments in benefits, copays and investment in care management.

MA plans agree that higher quality performance levels can be obtained by keeping out of pocket costs to a minimum for accessibility to care, implementing individual care plans for each beneficiary, supporting education/care coordination/support services efforts, requirements for patients to select and visit annually a PCP and aligning quality incentive programs across providers.

Extensive independent research has found causal relationship between out of pocket expenses and medication adherence. Inclusion in the part D LIS program reduces out of pocket expenses and therefore increases medication adherence for beneficiaries participating in the part D LIS program. Therefore participation and exclusion from the **part D LIS program is a confounding factor and should be accounted for in Star Rating measure adjustments.** Intra-plan performance comparisons, and recent studies performed at the national level, confirm that socio-demographic and statutory benefit disparities not accounted for in the current STARs program model cause unintended harm to PR beneficiaries.

It is our conclusion and understanding that plan performance and scientific evidence related to medication adherence support a concrete action and policy decision from CMS to reinstate the balance for beneficiaries in Puerto Rico by adjusting the methodology for NON-LIS areas. CMS would not be giving a different treatment to Territories. Instead, CMS would be adjusting the evaluation program to account for a difference established previously by law.

Given the high proportion of duals and low income beneficiaries in MAPDs in Puerto Rico this has been an extra challenge and has been a higher barrier to providing much needed care to beneficiaries on the island. **A Star Rating Measure risk adjustment factor for socio-economic status is fundamental to reverse a discriminatory penalization of MA beneficiaries due to systemic, (a) SES and (b) statutory factors.**

V. Definition of the Low Income Population and Sub-Groups of MA Beneficiaries in PR

The evaluation of dual vs. non-dual quality performance to assess causality between dual status and lower STAR ratings is confounded by differing income eligibility standards across States and Territories for the Medicaid Program. Puerto Rico has a Medicaid income eligibility standard of 87% FPL, which is significantly lower that most states. The difference is also increasing given the Medicaid expansion to 133% FPL that several states are implementing which is not applicable to Territories. In addition, the statutory exclusion of the Part D LIS leaves beneficiaries in Puerto Rico between 87% FPL and 150% FPL with no extra help compared to other beneficiaries. Therefore, in order to take into account actual income inequality, the Coalition members analyzed three groups of MA beneficiaries:

- **Duals** – Beneficiaries with incomes at or below 87% FPL.
- **Non-Dual** MA, MAPD – Group with a majority of low income beneficiaries below 150% FPL, and with the highest out of pocket costs (OOPC) which effectively reduce disposable income. For the purpose of this analysis does not include EGWP.
- **EGWP** (Employer Group) – Beneficiaries with incomes above 150% FPL.

The evaluations presented by individual plans in Puerto Rico (PR) and the Coalition evidence two main conclusions with respect to potential Star Rating measures case risk adjustments:

(1) Socio-economic and programmatic disparities create a non-dual population in Puerto Rico that has characteristics more similar to the dual population in the 50 States; and

(2) The comparison between EGWP beneficiaries and non-duals on the island provides a fairer evaluation of the causality between low income and lower STAR ratings.

In order to provide the best input possible to CMS we describe the socio-demographic profile of our MA beneficiaries according to the 3 main groups defined previously: Duals, Non-Duals and Employer (EGWPs). The table below describes the distribution of beneficiary enrollment by segment or program type comparing Puerto Rico and the National scenario.

Table 1

Medicare Enrollment in by Type of Program, Puerto Rico vs National

CMS Enrollment Reports October 2014

All Medicare Beneficiaries

	Puerto Rico		National	
Segment	**Beneficairies**	**%**	**Beneficairies**	**%**
Dual SNP	**271,941**	37%	**2,065,480**	4%
Non-Dual MA, MAPD	**199,397**	27%	**10,700,553**	20%
EGWP	**79,960**	11%	**3,012,234**	6%
Stand Alone PDPs	**23,340**	3%	**23,473,656**	44%
Traditional A&B, No Part D	**57,757**	8%	**14,479,431**	27%
Traditional A Only, Non Part D	**110,021**	15%		
Total	**742,416**	**100%**	**53,731,354**	**100%**

Only Beneficairies in MA

	Puerto Rico		National	
Segment	**Beneficairies**	**%**	**Beneficairies**	**%**
Dual SNP	**271,941**	49%	**1,705,849**	11%
Non-Dual MA, MAPD	**199,397**	36%	**11,060,184**	70%
EGWP	**79,960**	15%	**3,012,234**	19%
Total	**551,298**	**100%**	**15,778,267**	**100%**

This comparison reveals some basic facts of the Medicare program on the island, and the composition of the MA contract enrollment in general[1]:

- Overall, 74% of all Medicare beneficiaries receive benefits under the MA program compared to 29% nationally. In parallel, there is a 3% Stand Alone PDP enrollment on the island compared to 44% national average. These figures are an initial indicator of how income levels influence healthcare decisions in Puerto Rico indicating that beneficiaries don't consider stand alone PDPs that require an additional premium payment as an option.

- Duals in PR represent 49% of the enrollment in MA plans, compared to 11% national average. This reflects the complexity and extra challenge of serving poor populations for MA plans in Puerto Rico.

- Moreover, the 36% Non-Dual (Non-EGWP) enrollment has become a major challenge for plans on the island given that composition is predominantly low income beneficiaries (bellow 150% FPL) who are not eligible to Medicaid or Part D LIS extra help.

Why are Non-duals a sub-group of low income beneficiaries in PR?

MA plans are not required to gather income data for beneficiaries. This becomes a limitation to the analysis requested by CMS, given that the only member level measure of income available is through the eligibility process for the duals at 87% FPL or below ($10,000/yr). Additionally, beneficiaries that reside in Territories are not eligible to the regular LIS program and therefore there is no information to define the population group between 87% FPL (Medicaid eligibility) and the 150% FPL (Part D LIS eligibility). Notwithstanding, there is clear and reliable data to support our description of the non-dual population as predominantly low income.

In **Table 2** below we estimate the amount of low income (<150% FPL) MA beneficiaries in Non-Dual plans in Puerto Rico.

Based on the most recent US Census data **62%** of the 65 and older population in Puerto Rico is below 150% FPL. We used that proportion to estimate the number of Medicare beneficiaries that can be categorized as low income. After excluding all the D-SNP enrollees, **185,387** Medicare beneficiaries are still below 150%. We estimated how many of them are in Non-Dual MA plans by subtracting the beneficiaries that could be in other plan types. Specifically, we assumed that 75% of the Part A only beneficiaries in Puerto Rico are also low income, and therefore they cannot pay to enroll in Part B. We do not include 25% of the A Onlys to account for beneficiaries that have other plans or support from family plans. In addition, we assume that beneficiaries with Traditional Medicare A&B and/or Stand Alone PDPs do not include <150% FPL citizens. The resulting estimate is that at least **52%** of the Non-Dual MA beneficiaries are low income and would be eligible to LIS benefits if they lived in any State.

[1] From CMS MA and Part C Enrollment Reports and FFS Enrollment reports.

Table 2

Estimated Distribution of Medicare Beneficiaries by Poverty Level

Based on CMS Enrollment Reports Oct 2014 and US Census - American Fact Finder 2011-2013

Poverty Level Based on FPL	Distribution	Beneficiaries
Total	100%	**742,416**
Below 100 percent of the poverty level	39.80%	295,482
100 to 149 percent of the poverty level	21.80%	161,847
At or above 150 percent of the poverty level	38.40%	285,088

Estimate of MA Beneficiaries at 150% FPL or Below AND not in D-SNPs		
Total Medicare Beneficiaries	742,416	
Total Medicare Benficiaries at 150% FPL or Less (62% of Total)	**457,328**	
(-) Total D-SNP Beneficiaries at 87% FPL or Less	271,941	
Low income Medicare beneficairies NOT D-SNP	**185,387**	
(-) 75% of Part A Only Beneficiaries (assumed <150%FPL)	82,516	
(A) MAPD Beneficairies < 150% FPL w/out duals and part A Onlys	**102,872**	
(B) Total Non-Dual, Non-EGWP MAPD Beneficiaries in PR	**199,397**	
Resulting Estimate of < 150% FPL in the Non-Dual MA Plans	**52%**	**(A) / (B)**

This result is also consistent with estimates from the CMS Regional Office leaders as presented in the ***HHS Report to the President's Task Force on Puerto Rico,*** April 2013 (***Addendum 1 – separate zip file***).[2] The HHS report concludes that 497,000 Medicare beneficiaries could potentially be eligible for LIS extra benefits which would significantly improve their situation versus the current scenario.

Moreover, socio-demographic figures for Puerto Rico vs the national figures reveal a significantly higher proportion of the low income population 65 is living in poverty. **Table 3** provides selected figures from the ***American Fact Finder*** of the US Census, based on 2011-2013 data from the American Community Survey[3]. Beyond income disparities, the educational attainment figures are very revealing in an analysis of SES. While the national average of 65+ citizens that have less than a high school diploma is **20%**, in Puerto Rico **52%** of 65+ have less than a high school diploma. Additionally, earnings for those 65+ in PR are almost half the national average with similar costs of living expenses. Similarly, Social Security income in Puerto Rico averages **$12,140** which places these beneficiaries close to the 100% FPL (11,670 in 2014)[4], and approximately at 2/3 of the national average SS income for a 65+ citizen (**$18,815**).

Another key issue is Federal law excludes residents of PR from SSI. This effectively establishes a scenario for duals and low income on the island that:

- average 1/3 less in SS income (almost $7,000 per year less income),
- have no SSI (average of $6,000 per year in less income),
- have no Part D LIS (average of $1,000 less in benefits per year), and

[2] *Medicare part D Costs and Access to Prescription Drug Medications in Puerto Rico*. HHS Report to the Presidents Task for on Puerto Rico. Gutierrez, Cocchiara, Melendez, Bane, Alicea-Morales; pages 11-14, April 2013.

[3] American Fact Finder, US Census http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_3YR_S0103PR&prodType=table

[4] FPL in 2014: http://aspe.hhs.gov/poverty/14poverty.cfm

- do not have a Medicaid Part B buying program to offset the cost of monthly premiums (over $1,200 less in income due to NO help with Part B premium).

Added all up, disparities in the applicability of Federal programs to low income beneficiaries in Puerto Rico amount to over **$15,200** per year. Just this difference, means that similarly situated low income beneficiaries in other jurisdictions have disposable incomes two (2) times higher than beneficiaries residing in Puerto Rico.

Consequently, the degree of poverty with regards to disposable income and education levels is significantly higher in Puerto Rico because of **(a)** extremely lower levels of income ($) and **(b)** a greater proportion of the population living this situation.

Table 3

Selected Figures of the Population 65 and Older PR and US

From - US Census Bureau, American Fact Finder, 2011-2013 American Community Survey 3-Year Estimates

Subject	US	PR	PR - US
Total Population	43,056,386	581,981	(42,474,405)
Male	43.6%	43.4%	-0.2%
Female	56.4%	56.6%	0.2%
Median Age	73.7	73.4	(0)
Householder Living Alone	43.5%	37.1%	-6.4%
Hispanic or Latino Origin (Of any race)	7.3%	99.1%	91.8%
Educational Attainment			
Less than high school graduate	20.1%	52.5%	32.4%
High school graduate	33.5%	23.9%	-9.6%
Some college or associate degree	23.2%	10.5%	-12.7%
Bachelor's degree or higher	23.1%	13.1%	-10.0%
With any disability	36.3%	51.0%	14.7%
INCOME IN THE PAST 12 MONTHS (IN 2013 INFLATION-ADJUSTED DOLLARS)			
Households	26,374,021	361,828	(26,012,193)
With earnings	35.20%	25.00%	-10.2%
Mean earnings (dollars)	49,467	26,981	(22,486)
With Social Security income	90.80%	88.50%	-2.3%
Mean Social Security income (dollars)	18,815	12,140	(6,675)
With Supplemental Security Income	6.40%	0.90%	-5.5%
Mean Supplemental Security Income (dollars)	8,841	9,317	476
With cash public assistance income	1.80%	7.80%	6.0%
Mean cash public assistance income (dollars)	3,407	1,849	(1,558)
With retirement income	48.30%	30.20%	-18.1%
Mean retirement income (dollars)	23,707	14,159	(9,548)
With Food Stamp/SNAP benefits	8.70%	40.30%	31.6%
POVERTY STATUS IN THE PAST 12 MONTHS			
Population for whom poverty status is determined	41,752,673	575,221	(41,177,452)
Below 100 percent of the poverty level	9.50%	39.80%	30.3%
100 to 149 percent of the poverty level	11.00%	21.80%	10.8%
At or above 150 percent of the poverty level	79.60%	38.40%	-41.2%

To facilitate the description of the 3 distinct sub-groups identifiable in the MA plans serving in Puerto Rico, **Table 4** summarizes and compared some of the key characteristics:

Table 4
Summary Description of Main Socio-Demographic Groups in MAPD Plans in PR

Element	Dual Beneficiaries	Non-Dual	Employer Group (EGWP)
1. Enrollment	**272,000 (49%)**	**199,000 (36%)**	**80,000 (15%)**
2. Income	• Below 87% FPL • SS 2/3 of national average • Excluded from SSI income • No Medicaid Part B buy-in, beneficiary pays for part B premium	• Est. 50%+ below 150% FPL • SS 2/3 of national average • Excluded from SSI income • No Medicaid Part B buy-in, beneficiary pays for part B premium • No Medicaid Savings Programs that help pay Part B premium and cost-sharing for citizens up to 135% FPL.	• Retirement income, SS income
3. Education	• Low: most likely less than high school	• Large proportion has high school level or less	• Higher proportion with some college education or college
4. MAPD Benefits	• $0-$1 copays for core benefits in pharmacy and medical • Full Part D Gap coverage • (+) $10-$15 credit to part B member premium (increases income) • In general, the D-SNP program increases disposable income of this population • Estimated out of pocket costs (OOPC) for D-SNP benefits = less than $50 per year.	• Pharmacy copays average $4-$6 Gen, $15-$50 Brands, 25% specialty • No Part D Gap coverage for brands • Physician visits with increasing copays, $8-$15 specialists • In general, the MAPD offering lowers disposable income for this population relative to the dual population. • Estimated OOPC for MAPD offerings in PR without LIS = more than $2,500 per year.	• Similar to Non-Dual, some options with lower copays. • Additional member premium supporting, covered by employer (increasing disposable income). • Estimated OOPC similar to Non-Dual benefits, but employer covers approx $100 monthly on average ($1,000-$1,500 per year)
5. Relative MAPD Funding <u>within the PR Scenario</u>	• A/B Bid includes cost-sharing to Medicaid requirements (not as supplemental MA benefit subject to CMS retention) • Dual adjustment in risk score • NO Low Income Subsidy – more funding needed from MA to cover Medicaid benefits. This reduces the capacity of MA plans to help with the Part B premium • MA benchmarks have gone down -13% since 2011, total funding reduction estimated over -20%.	• Coverage for part D gaps bided as supplemental benefits (subject to CMS retention – MA rebate) • No dual adjustment between 87% FPL and 133% FPL; and also no LIS for those <150%FPL • MA benchmarks have gone down -13% since 2011, total funding reduction estimated over -20%.	• MA benchmarks have gone down -13% since 2011, total funding reduction estimated over -20%.
6. Healthcare delivery model history	• D-SNP beneficiaries in PR evolve from a mandatory Medicaid managed care system that started in the early 1990s.	• Beneficiaries used to FFS, non-coordinated model.	• Beneficiaries used to FFS, non-coordinated model.

Table 4 provides a summary that support two of our principal conclusions:

- Socio-economic and programmatic disparities create a non-dual population in Puerto Rico that has characteristics more similar to the dual population in the 50 States; and
- The comparison between EGWP beneficiaries and non-duals on the island provides a fairer evaluation of the causality between low income and lower STAR ratings.

Moreover, even when the causality test is more challenged when populations are compared across plans nationwide, for the purposes of the evaluation of the national STARs program, it is important to describe significant issues related to SES that need to be accounted for when adjusting Star Rating Measures for SES.

Table 5
Comparison of the Typical Low Benefits in PR vs Other Jurisdictions[5]

Sub-Group	Puerto Rico	National
Dual Eligible	• 87% FPL	• 100% FPL or more, supported by Medicare Savings Programs and Medicaid expansion
	• Excluded by law from Supplemental Security Income (SSI)	• SSI increases beneficiary income by more than $516+ per month on average for more than 8 million beneficiaries in the non-Territory jurisdictions.[6]
	• Pays the Part B premium $104.90 with an average help from MA program of $10-$15pmpm (credit to Part B under MA benefit).	• The beneficiary does not pay for the $104.90 part B premium; pays $0.[7] • Has $1,200+ more income a year than a dual in Puerto Rico just because of the part B premium.
	• No Part D LIS – limiting possibility to cover core benefits for a dual like the help with Part B premium. This puts more pressure on the MA funding to cover the dual program in PR.	• Part D LIS pays 100% of premium and copays down to $1-$3, $3-$6 levels.
	• No Federally funded expansion to 133% FPL	• Federal Medicaid expansion pays up to 133% FPL
87%FPL to 150% FPL	• No Part D LIS by law – direct impact on out of pocket costs	• Part D LIS helps all MAPD beneficiaries up to 150% FPL • In 2014, 11.3 million part D enrollees were receiving the LIS (approx 30%).[8]
	• Part D premium has to be covered with MA rebate dollars or with member premium.	• Part D premium 100% covered by the Part D LIS extra help for full LIS beneficiaries (up to 135% FPL). And 25%-75% covered for 135% FPL to 150% FPL.
	• Benefit has the full $320 deductible, 25% coinsurance and the gap • Plans use MA rebate to pay for deductible and Rx copays to ranges of $4-$6 Gen, $15-$50 Brand, 25% specialty. (still much higher than LIS)	• Rx Copay levels with the Part D LIS extra help = $1-$3 Gen, $3-$6 brand for <135% FPL • For 135% FPL to 150% FPL from $320 to $63 deductible, and 25% coinsurance reduced to 15%.
General	• Average SS income $12,000	• Average SS income $19,000
	• 30% with retirement income	• 48% with retirement income
	• 53% have education less than a high school diploma	• 20% have education less than a high school diploma

[5] A summary of extra help for duals is included in: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf
[6] Annual Report of the Supplemental Security Program, Social Security Administration, 2014.
[7] Medicare Part B Buy In Program – CMS Data 2000-2013 http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/BuyIns2013.pdf
[8] Kaiser Family Foundation Report (2014) in: http://files.kff.org/attachment/medicare-part-d-in-its-ninth-year-the-2014-marketplace-and-key-trends-2006-2014-report

From our review of the characteristics of the population scenarios as described above, there are key and primary conclusions to be emphasized:

(1) With regards to the intra-plan analysis for MA plans in Puerto Rico, the relationship between socio-demographic factors and lower STAR ratings is evidenced by the comparison of EGWP vs Non-Dual populations.

a. This finding is consistent with recently published studies performed by several institutions like the ***National Quality Forum*** (August 2014) and ***Inovalon*** (October 2013).

(2) There is a distinctive SES imbalance in the MAPD program platform for which quality is being evaluated by the STARs program in Puerto Rico. Mainly, statutory exclusion of Part D LIS benefits, along with other aggravating factors (no SSI), is directly affecting disposable income and access to care for the low income population (<150% FPL).

(3) Non-Dual population STAR ratings tend to be lower than both EGWP and Dual sub-groups in the MAPD plans in Puerto Rico.

(4) Dual vs Non-Dual and Dual vs EGWP comparison in Puerto Rico reveals that MA plans on the island have been able to achieve significant improvement in STAR ratings due to the implementation of special programs and the structuring of a unique platform under the Medicare Platino program.

Some of the key determinants that are part of the Medicare Platino program for duals in Puerto Rico are:

a. Dual program requirements keep OOPC to a minimum, including $0-$1 copays in pharmacy. The OOPC for a Medicare Platino D-SNP is less than $50 per year.

b. The Medicare Platino program started since 2006 (9 years ago) as a fully integrated Medicare-Medicaid program. This has allowed plans to implement individual care plans and quality incentive programs more effectively.

c. The dual population in Puerto Rico has evolved within a mandatory Medicaid managed care system since the early 1990s. This is a distinctive characteristic of the Medicare-Medicaid effort on the island which may now be supporting care coordination efforts under the D-SNP model.

Our review of the MAPD population in Puerto Rico, combined with plan-specific data analysis, and national level studies, call for policy changes with regards to:

(1) The need for a risk adjustment factor for socio-economic status as part of the MA and Part D STAR rating methodology. Given the proportion of duals and low income beneficiaries in MAPD in Puerto Rico, the extra challenge on the island has been a higher barrier for performance than in any other jurisdiction.

a. Establishing a SES risk factor adjustment methodology that **takes into account beneficiary income, benefits and education.** Currently SES is only considered for CAHPS purposes but not for any other measure.

b. **The need to account for statutory benefit differences, like LIS, which are evidently impacting critical measures like medication adherence, as supported by scientific research on the topic.**

VI. Exclusion from Part D LIS Program - Recognized benefit disparity having an impact on Medication Adherence

Extensive independent research has found causal relationship between out of pocket expenses and medication adherence. Inclusion in the part D LIS program reduces out of pocket expenses and therefore increases medication adherence for beneficiaries participating in the part D LIS program. Therefore participation and exclusion from the **part D LIS program is a confounding factor and should be accounted for in Star Rating measure adjustments.**

History

The PR Medicare Coalition for Fairness has worked to provide data, analysis and policy recommendations to the Administration for several years, and more intensively in the past 2 years, about health disparities on the island. Benefit disparity created by the exclusion of the regular Part D LIS program has been documented by the White House, HHS and CMS for many years. The list of documents below provides the evidence of the formal recognition of the problem, and the potential harm to Medicare beneficiaries that reside in Puerto Rico, particularly related to lack of patient adherence due to reduced disposable income to pay for treatment. We have submitted this documentation to the CMS team in October 2014, and also include it as part of the Addenda of this comment letter.

(1) **Obama 2008: Improving healthcare in Puerto Rico** – On page 2, the President's proposal for Puerto Rico includes the recognition of the exclusion of the Part D LIS benefits and the intention to eliminate this exclusion for residents of PR.
(2) **President's PR Task Force Report 2011** – Promoting Access to Healthcare – The White House recognizes the problem of the lack of LIS and requests HHS to evaluate the situation. This attachment includes just the 5 pages on healthcare; the full document can be found at http://www.whitehouse.gov/sites/default/files/uploads/Puerto_Rico_Task_Force_Report.pdf.
(3) **HHS Report to the President's Task Force on PR Status – Executive Summary - April 2013** – This is the 10 page summary of the report presented by Secretary Sebelius which addresses the topic of the Part D benefit difference in PR.
(4) **Medicare Part D Costs and Access to Prescription Drug Medications in Puerto Rico** – This is the section of the HHS Report to the White House that specifically refers to the issue of the part D benefit difference on the island, the significant socio-demographic factors, and the potential implications for access and medication adherence. The report is 40 pages about these topics.
(5) **Letter of the PR Coalition to President Obama – February 2014** – The PR Coalition sent this 4 page letter to President Obama to explain the situation of beneficiaries on the island and propose administrative adjustments. One of the proposals is related to the STARs program and the benefit differences with no LIS.
(6) **Report as Addendum to the letter of the President – February 2014** – This report describes specific responses and explanations of the Coalition given the findings and recommendations of the HHS April 2013 report. Specifically, the uneven impact of the lack of LIS on STAR rating performance and potential adjustments are discussed in pages 4-8.
(7) **HR3966 – Bill for the Extension of the LIS to Beneficiaries Residing in Territories** – This bill was presented by Resident Commissioner Pierluisi. However, there is no indication of evaluation by Congress at this point.

Impacts and Supporting Evidence

The relation between the lack of Part D LIS and access to prescription drugs has been described in the communications about this issue between the White House and HHS. The ***President's Task Force Report of March 2011*** precisely requests HHS to evaluate the potential barriers to access given the benefit disparity for low income individuals. Subsequently, the responding ***HHS Report to the President's Task Force***[9] in April 2013 describes how:

- over 400,000 beneficiaries are receiving less benefits than with LIS;
- the dual and low income beneficiaries on the island have "aggravating circumstances" with a low Medicaid eligibility threshold, the statutory exclusion from SSI, and the inexistence of the Medicare Savings programs that effectively increase income of beneficiaries over %100 FPL (in the states), AND
- CMS studies of beneficiaries that lose LIS benefits reveal the impact of access to LIS benefits in the spending on necessary prescription drugs.

From HHS Report to the President's Task Force, Section on Part D and Access, Page 15

> The study supports the view that cost-sharing aids beneficiaries in obtaining prescription medications necessary for the management of chronic conditions and loss of LIS status resulted in a decrease in average spending on necessary prescription drugs.

Our healthcare leadership in Puerto Rico has evaluated the need to do more surveys or analysis to prove the relation between fewer benefits, higher copays and the lower medication adherence rating for all plans on the island. Still, CMS has already produced and reviewed multiple studies confirming this relationship, and additional member surveys could not only be difficult, but also not add valid scientific evidence to merit the effort.

Accordingly, apart from the review in the aforementioned HHS report, we have reviewed research and guidelines performed and adopted by the Centers of Disease Control (CDC) in relation to medication adherence. One of the research efforts directly tied to this topic is included in the material of the CDC-supported **Community Guide**[10]**.** The review produced includes a multitude of formal scientific studies that validate the relation between out of pocket costs and medication adherence for high blood pressure and high cholesterol patients.[11]

From the Community Guide Research Review

> **Cardiovascular Disease Prevention and Control: Reducing Out-of-Pocket Costs for Cardiovascular Disease Preventive Services for Patients with High Blood Pressure and High Cholesterol**
>
> **Summary of Task Force Recommendations and Findings**
> The Community Preventive Services Task Force recommends reducing patient out-of-pocket costs (ROPC) for medications to control high blood pressure and high cholesterol when combined with additional interventions aimed at improving patient–provider interaction and

[9] *Medicare part D Costs and Access to Prescription Drug Medications in Puerto Rico*. HHS Report to the Presidents Task for on Puerto Rico. Gutierrez, Cocchiara, Melendez, Bane, Alicea-Morales; page 15, April 2013.
[10] See **The Community Guide** research and recommendations in http://www.thecommunityguide.org/cvd/ROPC.html
[11] Lists and links to the scientific evidence supporting the conclusions and recommendations of The Community Guide are included in: http://www.thecommunityguide.org/cvd/supportingmaterials/IS-ROPC.html

> patient knowledge, such as team-based care with medication counseling, and patient education. This recommendation is based on strong evidence of effectiveness in improving (1) medication adherence and (2) blood pressure and cholesterol outcomes.
>
> Limited evidence was available to assess the effectiveness of reducing patient out-of-pocket costs for behavioral counseling or behavioral support services independent of reducing patient costs for medications.

In addition, CDC intervention guidelines for medication adherence have adopted recommendations and analysis from the World Health Organization (WHO) which explicitly defines socio-economic factors as one of the 5 "Interacting Dimensions of NON-Aherence".[12] [13]

The five interacting dimensions are:

1. Social- and economic-related factors/interventions;
2. Health system/health care team-related factors/interventions;
3. Therapy-related factors/interventions;
4. Condition-related factors/interventions; and
5. Patient-related factors/interventions.

In 2012, the HHS ***Agency for Healthcare Research and Quality (AHRQ)*** also produced a thorough review of scientific literature about the topic "Medication Adherence Interventions: Comparative Effectiveness".[14] The agency performed a process that selected 68 articles with 62 studies on the topic, after reviewing 3,979 total references. The documented analysis is consistent with the validation that out of pocket costs are a determinant of medication adherence. As part of the conclusion the authors explain:

> "Despite the heterogeneity of adherence measurement, interventions tested, and characterization of interventions, we found the most consistent evidence of improvement in medication adherence for policy-level interventions to reduce out of pocket expenses, case management, and educational interventions across clinical conditions."

The scenario of MAPD plans in Puerto Rico presents concrete and identifiable indicators that present two sides of the spectrum with regards to the relative performance of medication adherence within the MAPD population:

(1) The non-dual population is statutorily affected by higher copays and out of pocket costs given NO-LIS, and present the lowest medication adherence performance; and

(2) The dual population reports higher adherence performance supported by extra help and benefits of $0-$1 copays while it also subject to additional care coordination efforts and individual care plans.

We may also add that the EGWP population has more support in the socio-economic factors and report higher medication adherence performance, even when cost-sharing and delivery model factors are very similar to those of the low income non-dual population in Puerto Rico.

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[12] The WHO Study "*Adherence to Long Term Therapies: Evidence For Action*" can be found at: http://apps.who.int/iris/bitstream/10665/42682/1/9241545992.pdf

[13] CDC Material, research and guidelines can be found at: http://www.cdc.gov/primarycare/materials/medication/

[14] http://effectivehealthcare.ahrq.gov/ehc/products/296/1249/EvidenceReport208_CQGMedAdherence_ExecutiveSummary_20120904.pdf

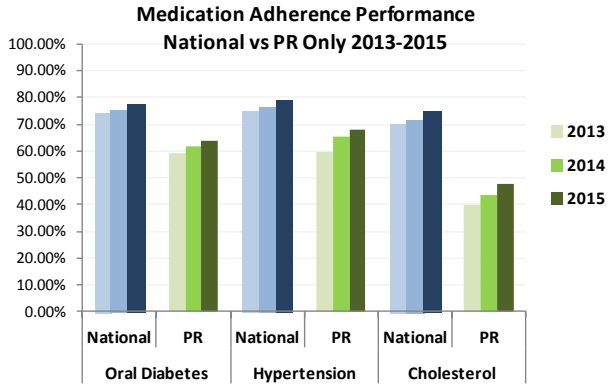
VII. Above Average Progress in Puerto Rico MA Plans, Intense Effort Against All Odds

The simple average of the Part C improvement measure of Puerto Rico plans is 4.11 compared to 3.5 for the rest of the plans in the nation. Similarly, the average of PR plans for Part D improvement 4.56 compared to 4.07 for the national average (**See Table 7**). These numbers are a simple indicator of the results care management, incentives and quality initiatives that MA plans in Puerto Rico have been implementing in recent years. Another particular measure that stands out is that both the "rating of health plan" and the "rating of drug plan" report above average performance for plans on the island. This result also relates to the general choice and perception of the Medicare beneficiaries in Puerto Rico who have chosen MA as their preferred option to receive Medicare benefits.

Unfortunately, positive progress on the island is still hindered by the imbalance created by two factors: **(a)** a disproportionate high number of low income beneficiaries, and **(2)** a distinct benefit disparity that impacts out of pocket cots and medication adherence measures. It is not difficult to see that medication adherence performance for plans in PR stands out from trends observed in the performance of any other measures. All 3 adherence measures basically average 1 Star, while the national average ranges from 3.22 to 3.50. Conversely, the specific medication adherence results reveal that performance in all 3 measures is improving on the island and that it is improving at a better rate than the national average. The data presented in **Table 6** below is probably the clearest evidence that socio-economic factors and statutory benefit disparities create an uneven platform under the current STARs methodology for the beneficiaries and plans in Puerto Rico. Although we are starting from al lower point, the accumulated benefit disparity imposes a "glass ceiling" with regards to catching up with national level results.

Table 6 (with Charts) – Lower level of Adherence but Improving at a Faster Rate

Year	Oral Diabetes		Hypertension		Cholesterol	
	National	PR	National	PR	National	PR
2013	74.39%	59.22%	74.67%	59.92%	69.94%	40.07%
2014	75.53%	61.58%	76.58%	65.25%	71.76%	43.58%
2015	77.37%	63.78%	78.83%	68.00%	74.76%	47.89%
2015-2013	2.97%	4.56%	4.16%	8.08%	4.82%	7.82%
% Change	4.00%	7.70%	5.57%	13.48%	6.90%	19.52%



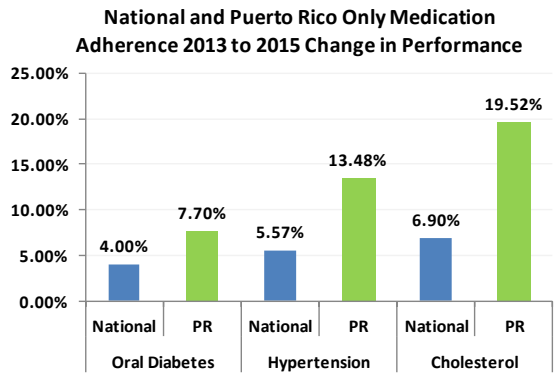


Table 7

National STAR Ratings compared to PR Plans by Measure - Simple Comparison

Measure	National Plans w/o Puerto Rico	Puerto Rico Plans	Variance PR vs. Nat Plans w/o PR
C11: Care for Older Adults – Functional Status Assessment	3.37	4.50	1.13
C27: Rating of Health Plan	3.38	4.22	0.84
C21: Reducing the Risk of Falling	3.31	4.11	0.80
C07: Monitoring Physical Activity	2.15	2.89	0.74
C03: Diabetes Care – Cholesterol Screening	4.13	4.78	0.65
C01: Colorectal Cancer Screening	4.15	4.78	0.62
C31: Health Plan Quality Improvement	3.50	4.11	0.61
C02: Cardiovascular Care – Cholesterol Screening	4.40	5.00	0.60
C26: Rating of Health Care Quality	3.65	4.11	0.46
C06: Improving or Maintaining Mental Health	2.45	2.89	0.44
C05: Improving or Maintaining Physical Health	4.63	4.89	0.26
C25: Customer Service	3.45	3.67	0.21
C22: Plan All-Cause Readmissions	3.01	3.22	0.21
C12: Care for Older Adults – Pain Assessment	3.99	4.17	0.17
C09: Special Needs Plan (SNP) Care Management	2.67	2.83	0.16
C20: Improving Bladder Control	1.90	2.00	0.10
C32: Plan Makes Timely Decisions about Appeals	4.19	4.13	-0.07
C33: Reviewing Appeals Decisions	3.66	3.57	-0.09
C10: Care for Older Adults – Medication Review	3.93	3.83	-0.10
C15: Diabetes Care – Kidney Disease Monitoring	4.17	4.00	-0.17
C23: Getting Needed Care	3.40	3.22	-0.18
C29: Complaints about the Health Plan	4.22	3.89	-0.33
C08: Adult BMI Assessment	3.84	3.33	-0.50
C14: Diabetes Care – Eye Exam	3.73	3.22	-0.51
C13: Osteoporosis Management in Women who had a Fracture	2.11	1.43	-0.68
C30: Members Choosing to Leave the Plan	4.29	3.56	-0.74
C18: Controlling Blood Pressure	3.71	2.78	-0.93
C16: Diabetes Care – Blood Sugar Controlled	3.36	1.56	-1.80
C17: Diabetes Care – Cholesterol Controlled	3.58	1.56	-2.02
C19: Rheumatoid Arthritis Management	3.54	1.38	-2.17
C04: Annual Flu Vaccine	3.32	1.00	-2.32
C24: Getting Appointments and Care Quickly	3.59	1.22	-2.36
C28: Care Coordination	3.48	1.11	-2.37
Part C Average Rating	**3.52**	**3.24**	**-0.28**

Measure	National Plans w/o Puerto Rico	Puerto Rico Plans	Variance PR vs. Nat Plans w/o PR
D10: Diabetes Treatment	3.41	5.00	1.59
D02: Appeals Upheld	3.73	5.00	1.28
D01: Appeals Auto–Forward	3.48	4.33	0.85
D05: Drug Plan Quality Improvement	4.07	4.56	0.49
D06: Rating of Drug Plan	3.53	4.00	0.47
D09: High Risk Medication	3.16	2.89	-0.27
D03: Complaints about the Drug Plan	4.23	3.89	-0.34
D04: Members Choosing to Leave the Plan	4.22	3.56	-0.67
D08: MPF Price Accuracy	4.57	3.89	-0.69
D07: Getting Needed Prescription Drugs	3.50	2.56	-0.94
D12: Medication Adherence for Hypertension (RAS antagonists)	3.22	1.00	-2.22
D11: Medication Adherence for Diabetes Medications	3.47	1.11	-2.36
D13: Medication Adherence for Cholesterol (Statins)	3.50	1.00	-2.50
Part D Average Rating	**3.70**	**3.29**	**-0.41**
Part D Average Rating w/out Med Adherence	**3.79**	**3.97**	**0.18**
Part C and D Average Rating	**3.57**	**3.25**	**-0.32**
Part C and D Average Rating w/out Med Adherence	**3.59**	**3.41**	**-0.18**

MA plans in Puerto Rico also average higher STARs ratings in many of the measures. However, Part C related measures that are reflecting lower than national average STARs are also those impacted most by

socio-economic factors. Provider – patient communications and relations are key factors for the "care coordination" and "getting appointments quickly" measures based on beneficiary replies to the CAPHS survey. The flu vaccine in Puerto Rico has also a cultural and education factor that impacts, while observed performance in outcomes measures are also more influenced by lifestyle, diet and similar factors that are less prevalent in higher income, higher education populations.

Given the increasing evidence (presented nationally and in the individual plan submissions by Puerto Rico plans) that confirms the causality between low income and lower STARs rating, there are key conclusions we derive from STAR rating averages in PR vs National:

(1) It is evident that medication adherence measures are an outlier in regards to the performance of plans in Puerto Rico.

(2) Without the effect of medication adherence measures, plans in Puerto Rico would average a Part D overall rating 8% higher than the national average. In addition total weighted points for the combined Part C and D STAR ratings improve from -10% national average to -4% national average if the medication adherence effect is not considered (**See Appendix 2**).

(3) Weighted at 3, medication adherence measures have been the reason for plans to have at least 0.5 lower star ratings, influenced by socio-demographic and benefit factors explained in previous sections.

(4) As plan specific submissions from Puerto Rico will reveal to CMS, the dual program on the island has exhibited results that can be valuable in identifying specific interventions and policy measures to increase quality ratings for dual and low income populations. Some key elements identified are:

- Extra funding and investment to reduce out of pocket costs to $0 or close to $0.
- PCP incentives directly tied to performance of the patient panel of the physician.
- Specific incentives to support additional services, education, and reminders performed by community pharmacies.
- A multi-year progress of a mandatory managed care model that requires patients to know and visit their PCPs.

Input From our IPA Community

Particular input from our physician leaders emphasize that the 20 year care coordination experience of our primary care physicians operating in the MA platform has resulted in tangible quality improvement. Still, the funding reductions since 2012 are bringing back issues prevalent in PR due to a history of underfunding in Medicare and Medicaid. A historic underdevelopment of health information technology infrastructure and the increasing migration of physician specialist are also part of the problems being exacerbated by recent cuts. Puerto Rico has been managing care coordination and administering budgets for patient populations in the most limiting circumstances for many years. Assuring a minimum amount of resources will avoid undue reductions in benefits and access to care, while supporting an experienced primary care platform that is proving to be successful in managing the dual population.

According to the ***Puerto Rico IPA Association*** leaders, MA plans should be regarded as the Medicare model that has provided the operational and administrative solution, under a proper regulatory structure, that can generate the fastest path towards economic and quality goals. Physicians are concerned that cuts to MA funding, coupled with an uneven STARs evaluation, could provoke a huge set back in the healthcare community. With the adequate funding the MA platform in Puerto Rico has been supporting

cost-efficiency and improved quality of care at the same time, but regulatory action is needed to avoid this imminent risk.[15]

General Observation about the National / PR Comparison

Health plans, primary care physicians, pharmacies and the community of providers in Puerto Rico have proven that there are extra efforts and interventions that will improve medication adherence and quality measures for the lowest income populations. However, increasing MA benchmark reductions, sequestration, and the new health insurance providers' fee have aggravated the disparity in benefits and resources for beneficiaries on the island that directly impact performance.

We are extremely concerned that the current STARS methodology, mostly unadjusted for socio-economic factors and not accounting for the direct impact of the exclusion of the LIS to some measures, is unintentionally becoming an additional element of inequity contributing to health disparities among Medicare beneficiaries across the nation.

[15] Based on input and comments from Dr. José J. Vargas, president of the *IPA Association of Puerto Rico*. November 2nd 2014. – Dr. Vargas is a member of the Camdem Coalition of New Jersey and a leader of the Superutilizers program under the guidance of Dr. Jeffrey Brenner.

VIII. Current Impacts to Benefits and to Progressive Quality Improvement

Danger of a harmful cycle that exacerbates disparities between the rich and the poor

As we addressed the situation of Puerto Rico in the past year, we described a scenario that we named **"the triple penalty"** of the STARs program on the island as it currently works.

1. **Less benefits to start** - Low income beneficiaries in Puerto Rico (duals and non-duals) have disparate benefits with no LIS and higher out of pocket costs to access prescription drug benefits.

2. **Lower STARs, Less revenue next year** - Impacted by fewer benefits, plans in Puerto Rico get lower STAR ratings and therefore have higher barriers to reach additional resources in the form of the higher MA rebate percentage, and the Quality Performance Bonus (QPB) that increases the MA benchmark by 5% at 4.0+ STARs.

3. **Even less benefits to continue** – Impacted by the lower STAR ratings, plans in Puerto Rico have a disadvantage that keeps them from reaching the higher levels of MA rebate and/or the 5% increase in the MA benchmark. This in turn leaves plans with less funding to pay benefits and the cycle starts again at a much worse point # **1.** of this same list.

For 2014 STARs (2015 payment year), no beneficiaries on the island (0%) had benefits supported by the MA rebate at 65% (vs 50% at 3.0 STARs) or by the 5% increase in the MA benchmark. Compared to 0%, at the national level 82% of the MA beneficiaries had access to this extra resources. For 2015 STARs (2016 payment year), 75% of beneficiaries in Puerto Rico are in plans that reached 3.5 STARs so the situation improved. Still, 0% are in 4.0 STARs plans and therefore the 5% increase in the MA benchmark applies to 0% beneficiaries compared to 60% at the national level.

Table 8

Scenario of STARs 2014

Element Impacting Funding / Benefits	National	Puerto Rico
MA Benchmark 2011	**$787**	**$595**
MA Benchmark @ 3.0 STARs	$829	$550
MA Benchmark change vs 2011	5%	-8%
Beneficiaries in 3.5 STARs or more	82% of beneficiaries	0% of beneficiaries
Beneficiaries in 4.0 STARs or more	52% of beneficiaries	0% of beneficiaries
MA Rebate at 65% or more in 2015	82% of beneficiaries	0% of beneficiaries
MA Quality Bonus Payment in 2015	52% of beneficiaries	0% of beneficiaries

Scenario of STARs 2015

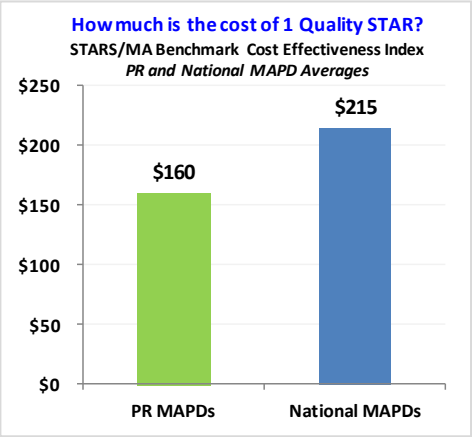
Element Impacting Funding / Benefits	National	Puerto Rico
MA Benchmark 2011	**$787**	**$595**
MA Benchmark	$766	$520
MA Benchmark change vs 2011	-3%	-13%
Beneficiaries in 3.5 STARs or more	88% of benficiaries	75% of beneficiaries
Beneficiaries in 4.0 STARs or more	60% of beneficiaries	0% of beneficiaries
MA Rebate at 65% or more in 2016	88% of benficiaries	75% of beneficiaries
MA 5% Quality Bonus Payment in 2016	60% of beneficiaries	0% of beneficiaries

The situation becomes more concerning considering recent methodology changes by CMS that defines non-predetermined variable 4 STAR thresholds. This becomes a new methodology element that may perpetuate distances between low income/low rated plans and higher income/higher rated plans unless socio-demographic adjustments are incorporated. In the case of Puerto Rico, most importantly the fair balancing measure has to include a policy that accounts for the benefit disparity defined by law.

Positive Element: We can do more with less (BUT there is a limit at the bottom)

Jurisdiction	Simple Average STAR Ratings	MA Benchmark 3.0 STARs	STARs Achieved Per Dollar $	Cost Per STAR
PR MAPDs	3.25	$520	0.0063	$160
National MAPDs	3.57	$766	0.0047	$215

As revealed by a simple calculation of the levels of STAR ratings reached by plans in relation to the average MA benchmarks, MAPD plans in Puerto Rico are improving quality at a lower cost relative to any other jurisdition.



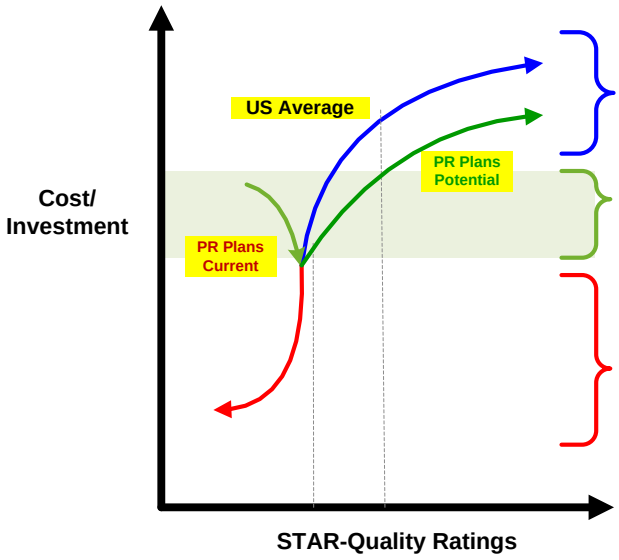
HOWEVER, results in medication adherence measures and in several outcomes measures are generating the situation described below. Increasing cuts in MA, coupled with persisting exclusion of key benefits like LIS, are directly impacting quality and plan performance for the 550,000 MAPD beneficiaries on the island.

The fact that the current STARS model, with the linked MA funding (incentive) structure, does not account for socio-demographic factors and for statutory benefit differences is unintentionally aggravating the situation for **(a)** the poorest populations, and for **(b)** the most cost-effective MA programs in the nation. The program needs to get back to MA/PD funding levels similar to 2011 in order to maintain reasonable access and benefits.

Adverse Element: DANGER and URGENCY – Disparities are widening and barriers increasing

The chart below illustrates how the situation in Puerto Rico needs urgent action to avoid restricting beneficiary access and quality.

Illustrating:
The Cost/Investment to Quality Improvement Relation
DANGER of MA cuts and benefit disparities becoming barriers to Quality and Access for beneficiaries in PR



(A)
The average MAPD plans in the nation are at a higher level of funding, and have extra help of Medicaid and Part D LIS to lower OOPC for the poor. Quality ratings and incentives help maximize cost/quality ratio.

(B)
Puerto Rico MAPD plans are increasingly implementing efforts to do more with less. And quality performance is revealing higher & faster improvement at a lower cost.
BUT this scenario is at risk with recent cuts and benefit disparities. PR has reached a ceiling in the cost/quality ratio.

(C)
The danger zone. MA funding and benefit exclusions in Puerto Rico are already at a bottom level where they become a barrier and provoke increases in access limitations and hinder quality improvement.

IX. Findings and Conclusions of Consensus

In preparation of this report for CMS, we have discussed the conclusions of intra-plan analysis performed by the major MA plans on the island. We also have discussed the STAR rating analysis between the dual and non-dual population with other stakeholder leadership including community pharmacies, IPAs and physicians. Even when specific data is being submitted in individual plan submissions, the following are key findings and conclusions supported across plans.

Findings

1. **MA plans in Puerto Rico have generated significant quality improvement, HOWEVER socio-demographic and statutory benefit disparities not accounted for in the current STARs program model are creating unfair results and causing unintended harm to for PR beneficiaries.**

2. The population profile and the Medicare benefits in Puerto Rico are distinct compared to the National scenario used to determine STAR rating performance goals and thresholds.

3. The Dual/Non-Dual comparison in Puerto Rico is not necessarily the same representation of low income vs higher income populations that may be reflected in the rest of the jurisdictions.

4. Non-Duals in Puerto Rico may effectively have lower disposable incomes than duals due to: a very low Medicaid eligibility level (87% FPL), higher OOPC for MAPD benefits, and the statutory exclusion from the Part D LIS extra help.

5. The EGWP/Non-Dual comparison for MAPD beneficiaries on the island is a more appropriate comparison of low income vs higher income populations.

6. The Dual population in Puerto Rico pays $0 copays for most benefits and participates in a D-SNP program that is fully integrated with Medicaid and that evolved from a strict Medicaid managed care program that began in the 1990s.

7. Dual beneficiaries in Puerto Rico (with distinct benefit and delivery model characteristics) tend to have higher STAR ratings than Non-Duals (who are largely low income beneficiaries without extra help). There is a basic difference between these 2 populations in the fact that Non-Duals excluded from Par D LIS benefits have significantly higher copays for prescription drugs and core benefits, whereas duals are at $0 for most core benefits. Non-dual beneficiaries between 87% FPL and 135% FPL are also excluded from the extra help of the Medicare Savings Programs that in the rest of the jurisdictions pay for the Part B premium and some of the Parts A and B cost-sharing.

8. EGWP beneficiaries (more income, more education) in Puerto Rico tend to have higher STAR ratings than Non-Duals (lower income, lower education).

Conclusions

1. Data from plans in Puerto Rico evidences the amount of extra effort and investment needed to improve STAR ratings considering socio-demographic factors (income, education). Historic mandatory Medicaid managed care since the 1990s and the fully integrated Medicare-Medicaid program established since 2006 (Medicare Platino) have created a platform that fosters quality improvement for MA duals in PR.

2. STAR ratings in Puerto Rico are particularly affected by approximately 50% of the Non-Dual population who is also largely low income BUT does not receive the extra help to pay for prescription drugs (NO Part D LIS and No Medicaid help).

3. There is a benefit imbalance in the situation of the low income beneficiaries in Puerto Rico created by statute (MMA 2003) which is adversely and disproportionately affecting the MA program STAR rating performance on the island.

4. Scientific research largely studied and adopted by the CDC clearly demonstrates a link between socio-economic factors, cost-sharing and medication adherence.

5. The 550,000+ Medicare Advantage beneficiaries in Puerto Rico are affected by an unintended inequity in the STAR rating methodology due to 2 key facts:

    a. There is no socio-demographic adjustment and MA plans in Puerto Rico serve almost 50% dual eligible beneficiaries at 87% FPL and below;

    b. There is no equalizing adjustment in the STAR ratings to account for the recognized benefit disparity defined by law with the exclusion of the Part D LIS for residents of the Territories.

X. Creating Balance and Objectivity in Regulatory Methodology when Starting from an Uneven Statutory Platform

We understand that CMS is carrying out an important effort to protect the objectivity and equity of the methodology and the policies that govern the operation of the STAR rating program. The ***PR Medicare Coalition for Fairness*** leaders and supporters are fully aligned with such goals and overarching principles.

Unfortunately, and due to circumstances beyond the scope of CMS, the Medicare benefits in Puerto Rico under Part D where not applied in the same manner for Medicare beneficiaries that reside in the Territories, compared to the rest of the jurisdictions. This legal fact creates an imbalance in the prescription drug program at the benefit level, and at the statutory level. At the regulatory level, CMS continuously seeks to operate an innovative and quality-fostering STARs program on equitable terms across the nation.

It is our conclusion and understanding that plan performance and scientific evidence related to medication adherence support a concrete action and policy decision from CMS to reinstate the balance for beneficiaries in Puerto Rico by adjusting the methodology for NON-LIS areas. CMS would not be giving a different treatment to Territories. Instead, CMS would be adjusting the evaluation program to account for a difference established previously by law.

Taking action is necessary to avoid exacerbating the negative consequences for the beneficiary that already exist from the statutory exclusion of low income benefits just because a beneficiary lives in the one of the US Territories.

XI. Recommended Alternatives for Regulatory Adjustments

Recommendations of Policy Adjustments Needed in the Short Term

Recommendation #1 - Assure the **integrity, balance and objectivity** of the STARs program in Territories by accounting for statutory benefit disparities by:

a. Excluding medication adherence measures for Territories (No LIS) from the part D and overall plan rating calculation, until the benefit disparity is eliminated; or

b. Including medication adherence measures only within the improvement measure, but not the separate adherence measures to avoid the disproportionate impact of the benefit disparity; or

- This would effectively maintain a measurement of medication adherence for territories that could be positive or negative depending on plan performance. It presents an option to measure improvement in adherence without applying the stand alone adherence measures that are influenced by benefit disparities across jurisdictions.

c. Calculating medication adherence thresholds for NON-LIS areas separately.

- CMS calculates separate thresholds for all PDP plans and all MAPD plans. We understand the MAPD-NON-LIS category is legitimately different from the regular MAPD in order to have a separate threshold calculation.

Recommendation #2 - Include a socio-demographic adjustment to account for the extra effort needed to reach higher levels of performance within low income populations.

Recommendation #3 - Unless it is addressed by a more comprehensive socio-demographic adjustment, there should be a particular adjustment for the measure "members who leave the plan" in the case of contracts with high proportion of dual eligible who are allowed to change every month.

- The right to change plans every month for duals is naturally a significantly distinct rule from the regular lock in period for non-duals.

- The dual proportion of 11% at the national level is too distant from the 49% dual proportion in Puerto Rico for plans to be evaluated under the same thresholds with no adjustment. Contracts and markets with 25% or more proportion of duals will naturally exhibit a different rate of plan changes than plans or markets where the dual proportion is closer to the 11% average.

Recommendation #4 - For Non-Dual, Non-EWGP MAPDs, LIS eligible membership, allow for the definition of a an LIS version of MAPD products which considers enhancements to pharmacy cost-sharing as part of the regular Medicare benefit and not as supplemental benefit subject to MA rebate retention by CMS.

- For LIS eligible individuals, MAPD plans do not have to allocate MA rebate dollars for the coverage of the LIS level benefits. Under this recommendation, CMS would develop a special bid methodology where plans in NON-LIS areas would be able to cover LIS level benefits as a mandatory Medicare benefit not subject to the CMS retention applicable when paying supplemental benefits with MA rebate dollars.

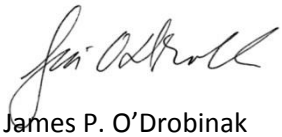
Recommendation #5 - For the purposes of the MA revenue impact, apply all these changes starting 2016 payment year to avoid impact to beneficiary in 2016, even if the 2015 STAR ratings are already public for other purposes.

- The June bid cycle for 2016 bids still allows CMS to define the policies for revenue components. Any financial implication of legitimate policy decisions made based on all the analysis done through this RFI should not be delayed as a matter of policy and beneficiary protection.

- Not implementing the 2016 impact by recalculating 2015 performance just for said purpose may result in lower benefits and higher OOPCs that would not occur under the new policies.

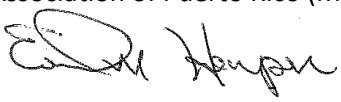
We commend CMS's initiative with this RFI, and look forward to policy and programmatic decisions that can generate a more equitable and balanced methodology to measure and incent quality improvement and performance across the nation.

Best Regards,



James P. O'Drobinak
CEO, Medical Card System, Inc
President, Medicaid and Medicare Advantage Association of Puerto Rico (MMAPA)

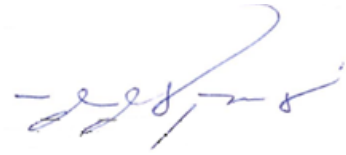
Orlando González Rivera, CPA
MMM Healthcare Inc. and PMC Medicare Choice President
MMAPA



Earl Harper
President, Humana Puerto Rico
MMAPA Board of Directors

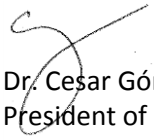
Eliot Pacheco
President
Puerto Rico Community Pharmacies Association

Lcdo. Jaime Plá-Cortés
President
PR Hospital Association



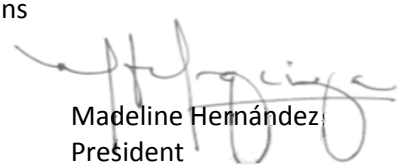
Dr. Joaquín Vargas
President, PR IPA Association

Victor Ramos
President
Puerto Rico College of Physicians and Surgeons



Dr. Cesar Gómez
President of PR Physical Medicine and Rehabilitation Association

José M. Izquierdo
President & Chairman of the Board
Puerto Rico Chamber of Commerce



Madeline Hernández
President
Triple-S Advantage
MMAPA Board of Directors

Wanda Vélez
President
Puerto Rico Medical Association

Cc:
Senator Ron Wyden, Chairman of the US Senate Finance Committee
Representative Dave Camp, Chairman of the US House of Representatives Ways and Means Committee
Hon. Alejandro García Padilla, Governor of Puerto Rico
Congressman Pedro R. Pierluisi
Senator Robert Menendez, US Senate
Senator Marco Rubio, US Senate
Representative Charles Rangel, US House of Representatives
Mr. Juan E. Hernández-Mayoral, Executive Director, PRFAA
Mr. Paul Dioguardi, Member of the White House Task Force on Puerto Rico and Director of Intergovernmental Affairs, U.S. Department of Health and Human Services
Mr. James Albino, Puerto Rico Affairs, the White House
Mr. Jim Kerr, CMS Regional Administrator, NYRO
Mr. Reginald Slaten, Associate Regional Administrator, New York Division of Medicare Health Plans Operations
Dra. Nilsa Gutierrez, MD, Chief Medical Officer, CMS Region II, New York
Michael Meléndez, Associate Regional Administrator, Medicaid and CHIP

Appendix 1 – Memorandum for Fairness, PR Medicare Coalition

Puerto Rico Medicare Coalition For Fairness
August 28, 2014

We, the undersigned, are all advocates and community stakeholders of the healthcare segment in the Commonwealth of Puerto Rico.

We believe that the fundamental principle of access to quality healthcare is an inalienable human right.

We acknowledge the **Puerto Rico Medicare Coalition For Fairness** and its sole mission of seeking more financial support for the beneficiaries of the Commonwealth of Puerto Rico.

We vow to be active members of the Puerto Rico Coalition for Fairness and to call upon the US Congress and the Obama Administration to protect the rights of US citizens residing in Puerto Rico. The federal government's policies of healthcare underfunding for US citizens residing in Puerto Rico have created a fragile healthcare delivery system.

The US Congress and the Obama Administration must address and resolve the historically unfair treatment of funding for healthcare in Puerto Rico. Specifically, we propose and request that the US Congress and the Obama Administration pass or approve the following legislative and regulatory amendments in order to rebuild the healthcare delivery system and protect the rights of US citizens residing in Puerto Rico:

Administrative

1. **NEW Federal Health Insurance Fee**: The new "Health Insurance Providers Fee" imposed by the ACA to Territories creates an incongruent and unbalanced implementation of the law based on the inapplicability of many provisions. Territories should be deemed not covered by this fee given the inapplicability of essential provisions related to it in the same law.
2. **MA ESRD Benchmarks**: ESRD MA Benchmarks (MA funding for ESRD patients) for PR has been reduced by -30% from 2012 to 2015 (over $2,000pmpm lost), and significantly more than any other jurisdiction. CMS should work with PR stakeholders to revisit the formula and data to find potential fixes to this disparity.
3. **Part A Payment Formula**: CMS should revisit the Part A fees for Puerto Rico to adequately reflect the costs of operations in the island, in particular the non-labor costs. This also creates an undue reduction in MA funding.
4. **FFS Physician Fees:** Make adjustments for Puerto Rico: Medicare FFS rates in PR are significantly lower due to geographical adjustments. This also impacts MA given the new ACA formula.
5. **Adapt Medication Adherence Thresholds for PR Plans to adjust for benefit difference due to NO-LIS**: The lack of Part D Low Income Subsidy means that the program is statutorily different in Territories where MAPD and Part D plans have less benefits relative to other jurisdictions. CMS should develop NON-LIS area thresholds for adherence measures to avoid a double penalty that is unfairly lowering STAR ratings.

Legislative

1. **Minimum MA Rate for Low Costs Areas:** Low cost areas in the Nation are at risk of falling into a "race towards the bottom" with regards to MA funding due to the nature of the new formula implemented by the ACA. Rather than a percentage based minimum MA benchmark, Congress should enact a model that establishes a minimum amount of funding for a Medicare beneficiary no matter where they reside in the US. It should be a specific dollar amount. Puerto Rico has seen the largest MA rate cut in all the US since 2011. A dollar minimum would protect the poorest counties, mitigate the trend of increasing disparities, and support what could become the most cost-efficient, high quality, Medicare areas in the Nation.
2. **Part D LIS:** Beneficiaries residing in Puerto Rico and the Territories are excluded from these extra Part D benefits for people up to 150% FPL. Congress should eliminate this benefit disparity for Medicare beneficiaries that reside in Territories.
3. **Part A payments to PR hospitals:** Congress should amend the law to apply the National average costs in the payment formula to 100% of the formula like in every other jurisdiction. Today, there is a statutory exception for Puerto Rico to lower the fees by using National figures only for 75% of the formula.
4. **Hospice Services:** The carve out of the hospice benefits from MA plans creates fragmentation of care and has created a reduction of 10%-12% in the estimated FFS costs that is used to calculate MA rates. Congress should implement MedPac recommendation about integrating the hospice benefit into the MA coverage and MA rate development.

We also support the Medicare funding for *Electronic Health Record* development in Puerto Rico hospitals as referenced in H.R. 1379 and S. 636, which should be addressed by the US Congress and the Obama Administration.

We will advocate and publicly support these initiatives as one of the largest and most important priorities in 2014 and beyond. We hereby pledge the support of my organization on behalf of the *Puerto Rico Medicare Coalition For Fairness* by executing this Memorandum of Agreement, in San Juan, Puerto Rico, on August 28, 2014.

Name	Affiliated Organization
	Medicaid & Medicare Advantage Association of Puerto Rico (MMAPA)
	Puerto Rico Community Pharmacies Association
	Primary Health Association of Puerto Rico
	IPA Association of Puerto Rico
	Puerto Rico Delegate to the American Medical Association

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Víctor Ramos	Puerto Rico College of Physicians and Surgeons
	American College of Healthcare Executives, PR Chapter
MD	Puerto Rico Medical Association
	Puerto Rico Hospital Association
	Puerto Rico Chamber of Commerce

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Appendix 2 – Comparison of STARs Averages, PR and National

National STAR Ratings compated to PR Plans by Measure - Weighted Points

Measure	Measure Weight	National Plans w/o Puerto Rico	Puerto Rico Plans	Variance PR vs. Nat Plans w/o PR	%
C31: Health Plan Quality Improvement	5.0	17.51	20.56	3.05	17%
C06: Improving or Maintaining Mental Health	3.0	7.34	8.67	1.33	18%
C27: Rating of Health Plan	1.5	5.07	6.33	1.27	25%
C11: Care for Older Adults – Functional Status Assessment	1.0	3.37	4.50	1.13	33%
C21: Reducing the Risk of Falling	1.0	3.31	4.11	0.80	24%
C05: Improving or Maintaining Physical Health	3.0	13.89	14.67	0.78	6%
C07: Monitoring Physical Activity	1.0	2.15	2.89	0.74	35%
C26: Rating of Health Care Quality	1.5	5.47	6.17	0.69	13%
C03: Diabetes Care – Cholesterol Screening	1.0	4.13	4.78	0.65	16%
C22: Plan All-Cause Readmissions	3.0	9.04	9.67	0.63	7%
C01: Colorectal Cancer Screening	1.0	4.15	4.78	0.62	15%
C02: Cardiovascular Care – Cholesterol Screening	1.0	4.40	5.00	0.60	14%
C25: Customer Service	1.5	5.18	5.50	0.32	6%
C12: Care for Older Adults – Pain Assessment	1.0	3.99	4.17	0.17	4%
C09: Special Needs Plan (SNP) Care Management	1.0	2.67	2.83	0.16	6%
C20: Improving Bladder Control	1.0	1.90	2.00	0.10	5%
C32: Plan Makes Timely Decisions about Appeals	1.5	6.29	6.19	-0.10	-2%
C10: Care for Older Adults – Medication Review	1.0	3.93	3.83	-0.10	-3%
C33: Reviewing Appeals Decisions	1.5	5.49	5.36	-0.13	-2%
C15: Diabetes Care – Kidney Disease Monitoring	1.0	4.17	4.00	-0.17	-4%
C23: Getting Needed Care	1.5	5.10	4.83	-0.27	-5%
C29: Complaints about the Health Plan	1.5	6.33	5.83	-0.50	-8%
C08: Adult BMI Assessment	1.0	3.84	3.33	-0.50	-13%
C14: Diabetes Care – Eye Exam	1.0	3.73	3.22	-0.51	-14%
C13: Osteoporosis Management in Women who had a Fracture	1.0	2.11	1.43	-0.68	-32%
C30: Members Choosing to Leave the Plan	1.5	6.44	5.33	-1.11	-17%
C19: Rheumatoid Arthritis Management	1.0	3.54	1.38	-2.17	-61%
C04: Annual Flu Vaccine	1.0	3.32	1.00	-2.32	-70%
C18: Controlling Blood Pressure	3.0	11.13	8.33	-2.79	-25%
C24: Getting Appointments and Care Quickly	1.5	5.38	1.83	-3.55	-66%
C28: Care Coordination	1.5	5.22	1.67	-3.56	-68%
C16: Diabetes Care – Blood Sugar Controlled	3.0	10.07	4.67	-5.40	-54%
C17: Diabetes Care – Cholesterol Controlled	3.0	10.73	4.67	-6.07	-57%
Part C Average Rating		**190.40**	**173.51**	**-16.88**	**-9%**

Measure	Measure Weight	National Plans w/o Puerto Rico	Puerto Rico Plans	Variance PR vs. Nat Plans w/o PR	%
D10: Diabetes Treatment	3	10.22	15.00	4.78	47%
D05: Drug Plan Quality Improvement	5	20.35	22.78	2.43	12%
D02: Appeals Upheld	1.5	5.59	7.50	1.91	34%
D01: Appeals Auto–Forward	1.5	5.22	6.50	1.28	24%
D06: Rating of Drug Plan	1.5	5.29	6.00	0.71	13%
D03: Complaints about the Drug Plan	1.5	6.34	5.83	-0.51	-8%
D08: MPF Price Accuracy	1	4.57	3.89	-0.69	-15%
D09: High Risk Medication	3	9.49	8.67	-0.82	-9%
D04: Members Choosing to Leave the Plan	1.5	6.34	5.33	-1.00	-16%
D07: Getting Needed Prescription Drugs	1.5	5.24	3.83	-1.41	-27%
D12: Medication Adherence for Hypertension (RAS antagonists)	3	9.66	3.00	-6.66	-69%
D11: Medication Adherence for Diabetes Medications	3	10.40	3.33	-7.07	-68%
D13: Medication Adherence for Cholesterol (Statins)	3	10.49	3.00	-7.49	-71%
Part D Average Rating		**109.21**	**94.67**	**-14.55**	**-13%**
Part D Total Points w/out Med Adherence		**78.66**	**85.33**	**6.67**	**8%**
Part C and D Total Points		**299.61**	**268.18**	**-31.43**	**-10%**
Part C and D Total Points w/out Med Adherence		**269.06**	**258.85**	**-10.21**	**-4%**

National STAR Ratings compated to PR Plans by Measure - Simple Comparison

Measure	2014			2015			Change from 2015 - 2014	
	National Plans w/o Puerto Rico	Puerto Rico Plans	Variance PR vs. Nat Plans w/o PR	National Plans w/o Puerto Rico	Puerto Rico Plans	Variance PR vs. Nat Plans w/o PR	National	PR
C01: Breast Cancer Screening	3.24	4.00	0.76					
C02: Colorectal Cancer Screening	3.89	4.58	0.70	4.15	4.78	0.62	0.27	0.19
C03: Cardiovascular Care – Cholesterol Screening	4.26	5.00	0.74	4.40	5.00	0.60	0.14	0.00
C04: Diabetes Care – Cholesterol Screening	3.78	4.33	0.55	4.13	4.78	0.65	0.35	0.44
C05: Glaucoma Testing	3.42	2.83	-0.59					
C06: Annual Flu Vaccine	3.49	1.00	-2.49	3.32	1.00	-2.32	-0.17	0.00
C07: Improving or Maintaining Physical Health	4.47	4.67	0.20	4.63	4.89	0.26	0.16	0.22
C08: Improving or Maintaining Mental Health	1.97	1.92	-0.05	2.45	2.89	0.44	0.48	0.97
C09: Monitoring Physical Activity	2.35	3.42	1.06	2.15	2.89	0.74	-0.21	-0.53
C10: Adult BMI Assessment	3.78	3.17	-0.62	3.84	3.33	-0.50	0.06	0.17
C09: Special Needs Plan (SNP) Care Management				2.67	2.83	0.16		
C11: Care for Older Adults – Medication Review	3.59	2.71	-0.88	3.93	3.83	-0.10	0.34	1.12
C12: Care for Older Adults – Functional Status Assessment	3.41	3.29	-0.12	3.37	4.50	1.13	-0.03	1.21
C13: Care for Older Adults – Pain Screening	3.18	3.00	-0.18	3.99	4.17	0.17	0.82	1.17
C14: Osteoporosis Management in Women who had a Fracture	1.93	1.78	-0.15	2.11	1.43	-0.68	0.18	-0.35
C15: Diabetes Care – Eye Exam	4.00	3.00	-1.00	3.73	3.22	-0.51	-0.27	0.22
C16: Diabetes Care – Kidney Disease Monitoring	4.53	4.58	0.05	4.17	4.00	-0.17	-0.36	-0.58
C17: Diabetes Care – Blood Sugar Controlled	3.38	1.50	-1.88	3.36	1.56	-1.80	-0.03	0.06
C18: Diabetes Care – Cholesterol Controlled	3.59	1.83	-1.76	3.58	1.56	-2.02	-0.01	-0.28
C19: Controlling Blood Pressure	3.53	2.42	-1.12	3.71	2.78	-0.93	0.17	0.36
C20: Rheumatoid Arthritis Management	3.71	1.73	-1.99	3.54	1.38	-2.17	-0.17	-0.35
C21: Improving Bladder Control	2.26	3.00	0.74	1.90	2.00	0.10	-0.36	-1.00
C22: Reducing the Risk of Falling	3.35	4.42	1.06	3.31	4.11	0.80	-0.04	-0.31
C23: Plan All-Cause Readmissions	3.49	3.58	0.10	3.01	3.22	0.21	-0.47	-0.36
C24: Getting Needed Care	3.56	3.58	0.02	3.40	3.22	-0.18	-0.16	-0.36
C25: Getting Appointments and Care Quickly	3.56	1.50	-2.06	3.59	1.22	-2.36	0.03	-0.28
C26: Customer Service	3.48	3.50	0.02	3.45	3.67	0.21	-0.03	0.17
C27: Rating of Health Care Quality	3.64	4.27	0.63	3.65	4.11	0.46	0.01	-0.16
C28: Rating of Health Plan	3.43	4.00	0.57	3.38	4.22	0.84	-0.05	0.22
C29: Care Coordination	3.50	1.25	-2.25	3.48	1.11	-2.37	-0.01	-0.14
C30: Complaints about the Health Plan	3.05	2.33	-0.72	4.22	3.89	-0.33	1.17	1.56
C31: Beneficiary Access and Performance Problems	3.37	2.58	-0.79					
C32: Members Choosing to Leave the Plan	3.79	2.00	-1.79	4.29	3.56	-0.74	0.50	1.56
C33: Health Plan Quality Improvement	3.51	3.50	-0.01	3.50	4.11	0.61	-0.01	0.61
C34: Plan Makes Timely Decisions about Appeals	4.14	3.91	-0.23	4.19	4.13	-0.07	0.05	0.22
C35: Reviewing Appeals Decisions	3.33	2.50	-0.83	3.66	3.57	-0.09	0.33	1.07
C36: Call Center – Foreign Language Interpreter and TTY Availability	4.47	3.67	-0.80					
Part C Average Rating	**3.48**	**3.07**	**-0.42**	**3.52**	**3.24**	**-0.28**	**0.04**	**0.18**

Measure	National Plans w/o Puerto Rico	Puerto Rico Plans	Variance PR vs. Nat Plans w/o PR	National Plans w/o Puerto Rico	Puerto Rico Plans	Variance PR vs. Nat Plans w/o PR	National	PR
D01: Call Center – Foreign Language Interpreter and TTY Availability	3.13	1.67	-1.47					
D02: Appeals Auto–Forward	3.29	3.08	-0.21	3.48	4.33	0.85	0.19	1.25
D03: Appeals Upheld	3.26	2.00	-1.26	3.73	5.00	1.28	0.47	3.00
D04: Complaints about the Drug Plan	3.11	2.33	-0.77	4.23	3.89	-0.34	1.12	1.56
D05: Beneficiary Access and Performance Problems	3.41	2.58	-0.83					
D06: Members Choosing to Leave the Plan	3.73	2.00	-1.73	4.22	3.56	-0.67	0.50	1.56
D07: Drug Plan Quality Improvement	3.67	4.42	0.75	4.07	4.56	0.49	0.40	0.14
D08: Rating of Drug Plan	3.47	4.17	0.69	3.53	4.00	0.47	0.05	-0.17
D09: Getting Needed Prescription Drugs	3.64	2.10	-1.54	3.50	2.56	-0.94	-0.14	0.46
D10: MPF Price Accuracy	3.92	3.67	-0.25	4.57	3.89	-0.69	0.66	0.22
D11: High Risk Medication	3.49	3.33	-0.16	3.16	2.89	-0.27	-0.33	-0.44
D12: Diabetes Treatment	3.15	5.00	1.85	3.41	5.00	1.59	0.26	0.00
D13: Medication Adherence for Diabetes Medications	3.71	1.08	-2.63	3.47	1.11	-2.36	-0.24	0.03
D14: Medication Adherence for Hypertension (RAS antagonists)	3.74	1.17	-2.58	3.22	1.00	-2.22	-0.52	-0.17
D15: Medication Adherence for Cholesterol (Statins)	3.64	1.00	-2.64	3.50	1.00	-2.50	-0.14	0.00
Part D Average Rating	**3.49**	**2.64**	**-0.85**	**3.70**	**3.29**	**-0.41**	**0.21**	**0.65**
Part D Average Rating w/out Med Adherence	**3.44**	**3.03**	**-0.41**	**3.79**	**3.97**	**0.18**	**0.35**	**0.94**
Part C and D Average Rating	**3.49**	**2.94**	**-0.55**	**3.57**	**3.25**	**-0.32**	**0.09**	**0.31**
Part C and D Average Rating w/out Med Adherence	**3.47**	**3.06**	**-0.42**	**3.59**	**3.41**	**-0.18**	**0.11**	**0.35**