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

On behalf of Centene Corporation, I write to express Centene's continued support of the Request for Information (RFI) released by the Centers for Medicare and Medicaid Services (CMS) requesting information that demonstrates 1) that dual status causes lower MA and Part D quality measure scores, and 2) high quality performance in MA or Part D plans can be achieved in plans serving dual eligible beneficiaries. Given the extensive body of evidence documenting the impact of sociodemographic factors on the health of dual-eligible beneficiaries, and the growing body of evidence associating dual status with lower plan performance, it is critical that CMS ensures that health plans that focus on low-income individuals are treated equitably under the Medicare Star Rating system.

Centene currently operates six Dual Special Needs Plans (D-SNPs) and four Medicare-Medicaid Plans (MMPs) and currently serves only dual-status beneficiaries. As a result, in response to the main question posed - whether dual status causes lower Medicare Advantage (MA) and Part D quality measures - we unfortunately cannot provide conclusive data-driven evidence to illustrate causality because we lack a non-dual population for control purposes. In addition, we are also unable to prove causality with respect to the alternative question posed concerning whether high quality performance in MA or Part D plans can be achieved in plans serving dual-eligibles.

While we are limited in our ability to respond to this RFI, we believe that the two questions posed are critically important to dual-eligible beneficiaries and largely support the need for further research in this area. Appendix A highlights research we believe raise interesting insights. While the studies differ in their approach and methodology, the common thread they all share is that they ultimately conclude that demographic and/or socioeconomic factors do indeed influence health outcomes and consequently affect health plan performance on quality measures, especially for those health plans exclusively serving dual-eligible beneficiaries.

These findings align with Centene's experience. For example, when looking at our four D-SNP contracts currently reporting Medicare Star ratings, our case mix adjustment suggests that our beneficiaries are generally younger, less educated, less healthy, have more mental health problems and, by virtue of being enrolled under a D-SNP, are low-income and/or disabled.

In addition to facing complex health issues, a large number of our beneficiaries face day-to-day hardships related to their biopsychosocial needs (e.g., transportation and stable housing) that occur as a result of their lower socioeconomic status. As an organization, Centene is committed to working to minimize these barriers for our beneficiaries in order to improve their overall health and quality of life. However, even after attempting to minimize these barriers through supplemental services and benefits, we find that our beneficiaries are still in need of additional help in other areas of their life that often take priority over health. Nowhere is this more apparent than when it comes to breaks in the continuity of coverage and tracking beneficiaries' contact information (addresses and phone numbers). Appendix B highlights the number of enrollees that have experienced gaps in coverage (churn) in our four D-SNP contracts reporting on Stars.

Because beneficiary data is often inaccurate, Centene is constantly tracking, confirming and updating dual-eligible beneficiary information across our Medicare and MMP lines of business. Appendix C highlights recent information provided by LexisNexis on the accuracy of our contact information. Just looking at addresses, only 41% of the addresses we had on file were confirmed by the recent LexisNexis

data run. Addresses were updated for 47% of our enrollees, and, for 12% of our enrollees, we were unable to find a good address. Appendix C also illustrates that similar findings were documented for phone numbers. During the recent data run, 57% of the phone numbers we had on file for our beneficiaries were updated and we could not find a working phone number for 1% of our beneficiaries.

At the health plan level, our health plan in Wisconsin experienced similar difficulties in contacting new beneficiaries to conduct a benefit overview and to encourage new beneficiaries to partake in a health risk assessment. The health plan documented that they were only able to reach 50% of beneficiaries with multiple attempts, and, for 13% of those calls, the contact information appeared to be out-of-date resulting in the inability to leave a message for the new enrollee. For current beneficiaries, our health plan in Wisconsin also documented similar findings (Appendix D) in contacting beneficiaries as part of their larger diabetes care outreach program. These factors taken together oftentimes make it more difficult to locate and engage our beneficiaries, and ultimately reduces the number of beneficiaries that we are able to effectively engage and manage compared to non-dual MA plans.

In summary, although Centene is not in a position to prove that dual-status eligibility causes poor performance or that dual-status eligibility causes high-quality performance, our experience aligns with the growing body of research on this issue that raises significant questions related to how the Star Rating system impacts those plans that are committed to serving dual eligibles. Our beneficiaries face biopyschosocial hardships that make plan engagement, care coordination and disease management difficult. While the magnitude of impact that these factors have on our performance on quality measures is unclear, it is critical that CMS ensures that the Star Rating system is equitable to all health plans regardless of population mix. If the Star Rating system favors MA plans due to population mix, over time, dual-eligible beneficiaries will not get the care that they deserve and need since it will be disadvantageous for plans to focus on this population.

Thank you for the opportunity to comment and offer Centene's experience on this important topic. If you have questions, please contact me, Gale P. Arden, Vice President, Complex Care at 630-270-7015 or email, garden@centene.com.

Appendix A: Research Findings

Study	Date	Data Set	Comments
Inovalon: The impact of Dual Eligible Populations on CMS Five-Star Quality Measures and Member Outcomes in MA Plans[i]	10/2013	MORE Registry: 3.1 billion member-months from 2002 through September of 2013	Note: Inovalon is revising the study at the request of CMS.
NQF: Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors	8/2014		
AHIP Intra-Plan Analysis: Stars System's Disproportionate Impact of MA Plans Focusing on Low-Income Populations[ii]	2014	Trends in Star Ratings from 2011-2014 (plans with 50% or more duals vs. plans with less than 50%)	
Ingenix: The MA Stars Rating System and Dual Eligible Special Needs Plans: Is the Rating System Appropriate?[iii]	10/2010	2010 Performance Scorecards	
XL Health Inter-Plan Analysis	Private	Private	
Gateway Inter-Plan Analysis	10/2013	2013 Stars Ratings	
Milliman: Predictive Ability of External Characteristics on MA Contracts' STAR Ratings	10/2013	2013 Stars Ratings	
How Engaged Are Consumers in Their Health and Health Care, and Why Does It Matter[iv]	10/2008	2007 Health Tracking Household Survey	

i. http://www.inovalon.com/press-releases/2013/inovalon-releases-study-results-examining-cms-star-ratings-within-dual-eligible

ii. http://m.healthaffairs.org/blog/2014/09/22/medicare-advantage-stars-systems-disproportionate-impact-on-ma-plans-focusing-on-low-income-populations/

iii. http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP%20Stars%20Fact%20Sheet%20May%202012.pdf

iv. http://www.hschange.com/CONTENT/1019/

Appendix B: Medicaid Break in Coverage (Churn) Data

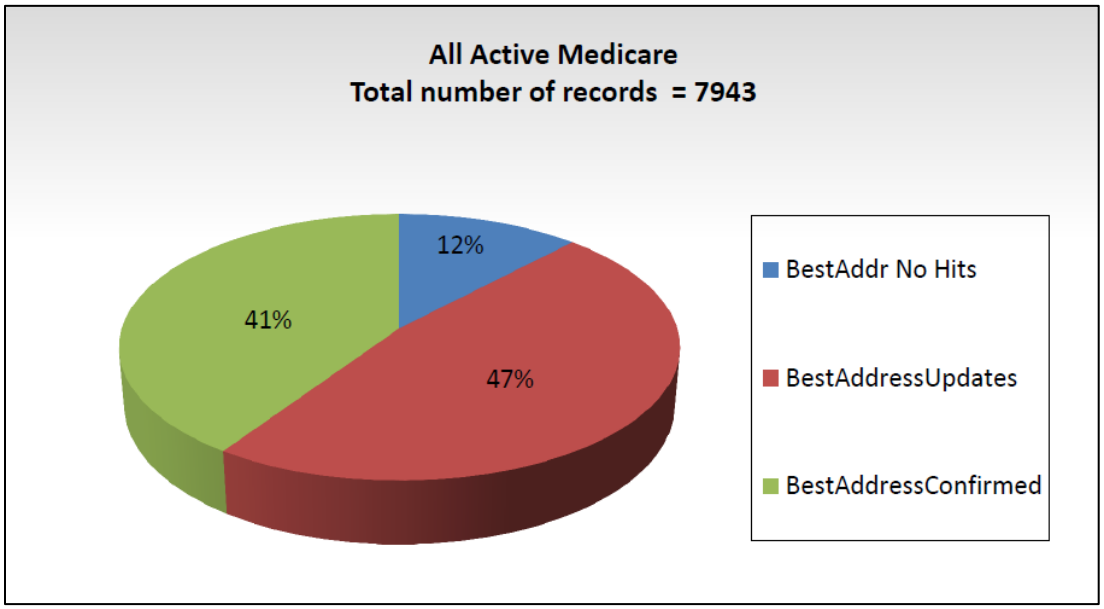
Background: Enrollee data was assessed from January 1, 2012 to October 1, 2014.The data illustrates the number of our D-SNP (only the four D-SNP's currently reporting on Stars) enrollees who experienced a break in Medicaid coverage during that given time period. For example, for members who had an effective start date of 2012, we documented churn to be 355, 675, and 2548 in 2012, 2013, and 2014, respectively. Generally churn is observed if an enrollee experiences fluctuations income or if an enrollee fails to submit timely reports to verify income or enrollment. It is our general belief that interruptions in Medicaid affect our D-SNP enrollees continuity in care and consequently might potentially impact our D-SNP enrollees overall health and well-being.

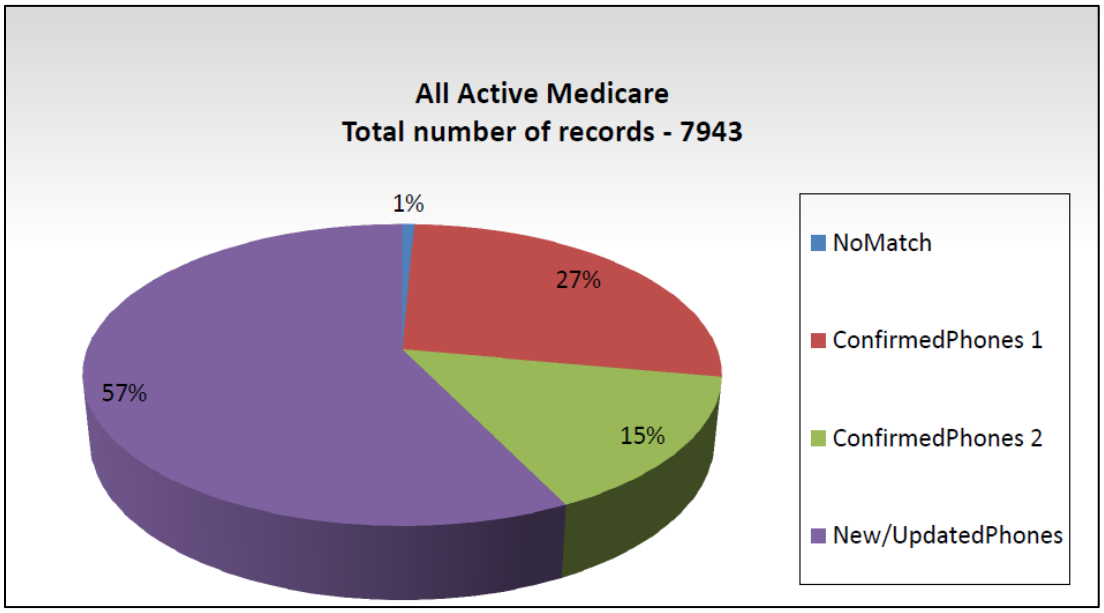
Effective Start and Effective End Category	Churn (N= number of enrollees)
2012 Start, 2012 End	355
2012 Start, 2013 End	675
2012 Start, 2014 End	2548
2013 Start, 2013 End	641
2013 Start, 2014 End	2297
2014 Start, 2014 End	2687
Grand Total	**9203**

Effective Start Date	Number of Enrollees (N)
2012	5553
2013	9306
2014	9122
Grand Total	**23981**

Source: Data collected from our four D-SNP Health Plans currently reporting on Medicare Stars

Appendix C: Medicare Address and Phone Contact Information LexisNexis Data Run





Note: confirmed phone 1 implies a match was found when our primary member contact number was checked against the LexisNexis database. Confirmed phone 2 implies a match was also found between the secondary contact number we had on file for the member and LexisNexis.

Appendix D: Managed Health Services (MHS) Wisconsin Diabetes Outreach Contact Attempts

Medium risk	
Total # reached out to:	148
Total live call attempts:	301
# with 3 attempts but no contact:	25
High risk	
Total # reached out to:	61
# with 3 attempts but no contact:	8

Source: Medicare data collected from MHS Wisconsin