Mercy Care Advantage HMO SNP

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VIA EMAIL – PartCandDStarRatings@cms.hhs.gov

Part C and D Star Ratings
Center for Medicare and Medicaid Services

Re: *Response to Request for Information Concerning D-SNP Model*

I am writing to you on behalf of Mercy Care Advantage (MCA), a Special Needs Plan (SNP) for Arizonans who qualify for both the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program, and for Medicare.

This letter is in response to the Centers for Medicare & Medicaid Services (CMS) request for information regarding the CMS Star rating system as it impacts the Dual Special Needs Plan (D-SNP) model for beneficiaries who are dually eligible for Medicaid and Medicare.

Over the years, CMS has made many positive changes to the Star Ratings Program that has generally been supported by the industry. However, it's been a long standing concern that there are significant differences in population characteristics and demographics in SNPs that service members with chronic conditions – and CMS should take these plan differences into account in its Star Ratings system. SNPs, which disproportionately serve 'dual eligible' seniors in Medicare, are impacted by social determinants (e.g. socioeconomic status) that are key drivers of health outcomes. We believe CMS should take these differences into account in its Star Ratings system and compare SNPs to SNPs and not include SNPs in the same Star Ratings system that serves a much healthier and higher income population.

Studies have demonstrated the correlation between the percentage of D-SNP members in a health plan and Star Ratings. For example, two comprehensive Ingenix Consulting analyses on behalf of the Association for Community Affiliated Health plans found the most common score for D-SNPs fell below the mode score for standard plans. (*"The Impact of Dual Eligible Populations on CMS Five-Star Quality Measures and Members Outcomes in Medicare Advantage Health Plans,"* Inovalon Research Brief, October 2013).

It is worth noting that the Star Ratings system already recognizes factors such as socio-economic status in the CAHPS survey measures, where CMS "case mix adjusts" results to account for differences among plans. Similarly, CMS should account for these differences across all Star measures, especially clinical measures where these differences have the most profound impacts.

I am proud of the service our plan provides for our dual eligible beneficiaries. In fact, an Avalere Health study found that MCA was more successful than traditional Medicare fee-for-service plans in these key measures of care for dual eligible members:

- 31% lower rate of hospitalization and 43% fewer days spent in the hospital
- 9% lower emergency use
- 21% lower readmission rate
- 3% higher use of preventive and ambulatory health care services.

D-SNP beneficiaries in Arizona receive integrated and coordinated care that is specifically and individually designed to meet their unique special needs. Our plan emphasizes interdisciplinary teams to support intensive case management and care coordination. Yet, despite this success, no amount of experience, good intentions or collaboration can overcome the obstacles to fully integrated health care that are embedded in the existing D-SNP program. The program is called "Special Needs" for a reason: the enrollees have complex health care issues. They are senior citizens living in poverty and younger people with physical and cognitive disabilities; they are sicker than the rest of the population; they have been diagnosed with a mental illness; they are candidates for institutionalization, frequently with severe and debilitating chronic conditions.

While we support CMS's objective of holding plans accountable for the quality of their services and outcomes, and of the concept of paying for performance, we strongly urge policymakers to consider the mounting evidence that suggests the Star Ratings system, as currently designed and applied to D-SNPs, poses a serious threat to the viability of the plans that are the best equipped and most adept at coordinating care for dual eligible beneficiaries.

The solution is to develop and apply structural changes to the system to correct the unintended consequences that adversely impact plans serving predominantly dual eligible beneficiaries. We recommend the following:

- D-SNPs should be compared to each other, rather than to those targeting broader, generally healthier segments of the senior population. CMS should establish a separate set of cut-points for plans that serve a minimum threshold percentage of SNP members.

- Measures should be risk-adjusted to account for socioeconomic factors that impact health outcomes, in the same way that CMS does now for the CAHPS survey measures

We share a mutual goal with CMS to ensure the Star Ratings program is working optimally and with transparency to improve the quality of care for Medicare beneficiaries. I am grateful for the opportunity to share my concerns with you on these critical issues at stake, and sincerely appreciate your reaching out to the D-SNPs to share their expertise as you consider changes to the current system.

Sincerely,

Mark Fisher
CEO and President

Cc: Kijuana Wright, AHCCCS