CareOregon Response to 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.

Thank you for this opportunity to comment on your request for information regarding star quality measurements for dual eligible Medicare Advantage beneficiaries. For reasons explained throughout these comments, CareOregon cannot provide comparative data to concretely connect our plan's population to the disparities we experience within the current star quality rating system. We are encouraged by the dual eligible study recently released by Inovalon, and hope that this comprehensive analysis will inform future changes that improve quality for all populations served through Medicare Advantage.

In a recent meeting with Melanie Bella, Director of the CMS/Federal Coordinated Health Care Office, a request was made for CareOregon to provide our measure-by-measure star rating quality data for the last 3 years; this information will be attached with the following comments. Thank you again for this opportunity to participate in improving the Medicare Advantage system, and we look forward to working with you all in the future.

We are CareOregon

CareOregon is a non-profit, tax-exempt 501(c) (3) Medicaid health plan serving low-income Oregonians throughout the state. CareOregon is also the parent company for Health Plan of CareOregon, Inc. CareOregon operates two Medicare Advantage Prescription Drug (MA-PD) plans under one contract. The larger of the two plans is a Special Needs Plan (D-SNP) serving approximately 9,500 individuals eligible for both Medicare and Medicaid. The smallest of the two plans serves approximately 1,300 low income Oregonians on the verge of special needs classification; many in this population are low income subsidy (LIS) eligible.

Our mission is building individual well-being and community health through shared learning and innovation. Our vision is healthy communities for all individuals, regardless of income or social circumstances. We focus on the total health of our members, not just traditional health care. In teaming up with members, their families and their communities, we help Oregonians live better lives, prevent illness and respond effectively to health issues. We do this by working to support health in the community as well as in clinics and hospitals.

In providing health plan services to four Coordinated Care Organizations (organizations that provide the Medicaid program), we directly serve approximately 250,000 Oregonians throughout the state. Our members receive care in community health centers, large health systems, academic health centers, private practice groups and hospital-affiliated group practices.

CareOregon Advantage Medicare Member Profile

Geographic Distribution	Demographics	Health Conditions	Mental Health/Substance Abuse	Utilization – Top 3
9 counties **83% metro (3 counties)** **17% non-metro (6 counties)**	**44% under age 65** **57% Female** **12% over the age of 80**	**11% Congestive Heart Failure** **16% Chronic Obstructive Pulmonary Disease** **30% Diabetic**	**10% Schizophrenia** **7% Bi-Polar** **12% Chronic Mental Illness** **25% Substance abuse disorders (D-SNP only)**	**31.5% Rx Costs** **25.5% Inpatient Care** **15% Outpatient and ER Costs**

The members that benefit from our D-SNP are a fragile population with limited financial resources. Furthermore, a high percentage of our D-SNP population suffers from a number of disabling, chronic physical and mental health conditions. As a non-profit organization, CareOregon entered the Medicare market place to provide excellent care for this specific, special needs population. We have consistently achieved a score of 3.5 on the CMS five quality star rating scale. While CareOregon hopes to grow our membership and improve the quality of care to Oregon's special needs population through targeted investments in the organization's operational structure, both efforts will be severely inhibited by the influence of the quality star rating payment structure currently utilized by CMS.

We believe that the current star quality rating system punishes health plans that serve a high concentration of D-SNP members. It appears as though health plans with an unusually high proportion of D-SNP/LIS members are penalized between ½ to 1 full rating star for focusing on this population. The current rating system is not adequately rewarding quality care to D-SNP/LIS beneficiaries and reallocates much needed programmatic funding away from this vulnerable population.

The makeup of CareOregon's special needs population - and lack of ability to charge premiums or spread risk with a large pool of non-SNP members - places the organization in a unique position; it appears as though the current system penalizes CareOregon for focusing specifically on this population. D-SNP and LIS population are more expensive to care for because they simply have more health care needs. Our case workers report that this population suffers from mental health problems that often compound the nature of our members' physical health problems. Some routine health issues that can normally be addressed through appropriate prescription medication are often times unavailable to the D-SNP/LIS population because of the potential for complications with other prescriptions and health issues.

Though the D-SNP/LIS population presents health plans with unique and costly health care issues, CareOregon remains committed to providing quality care to members enrolled in Medicare Advantage plans. CareOregon has applied our successful care coordination practices to the D-SNP/LIS population served within our Medicare Advantage plans. The positive results of care coordination have been beneficial to CareOregon's palliative care program, and stakeholders within the community know that CareOregon provides quality health care to the sickest, most vulnerable populations within the state of Oregon.

CareOregon's Palliative Care Program has also provided healthy outcomes for our D-SNP population. We have the only palliative care program in the state which focuses on the D-SNP/LIS population. This underserved population often receives substandard care for advanced care planning, symptom management and hospital utilization. Often times poor care translates into high utilization, poorer outcomes and greater suffering. CareOregon is proud to have a Medicare Medical Director that is a board certified palliative care physician who has helped the program grow by 20% in the last year. Without CareOregon Advantage, no other health plan in Oregon would develop palliative care for our sickest, most vulnerable members.

Unfortunately, CareOregon's success at caring for this population has made our organization a magnet for adverse risk. While we continue working to provide quality health care to people that other health plans seem to avoid, the economic analysis below makes clear the many factors which currently limit our ability to care for this population.

CareOregon Five Star Quality Data: 3 year Look-Back

CareOregon's performance over the last three years shows consistent improvement within many measures that comprise the CMS five star quality rating scale. At CareOregon, the dual eligible special needs population comprises approximately 90% of our MA-PD plan; our experience has made clear that this population presents unique health care challenges. The star quality rating system uses a bell curve scoring system that compares all health plans as though the population served has no impact on plan performance. We appreciate this opportunity to provide our data and experience in an effort to make clear how our CareOregon's MA-PD population inhibits our ability to achieve rewardable outcomes. While our small D-SNP population (and absent non-low income population) has limited our ability to collect data that conclusively proves the difficulties associated with the D-SNP population, a recent study by Inovalon makes clear the disparities that exist for MA-PD plans that serve a high proportion of D-SNP and Low income members.

Though CareOregon struggles to perform at the same level as health plans that serve lower proportions of the D-SNP/low income population, we still excel in many star quality measures. Furthermore, CareOregon has consistently improved in many of the star quality rating measures. Unfortunately, much of this improvement often goes unrewarded and is sometimes penalized. It appears as though the current payment structure rewards only large improvements within scoring measures. While we are proud of the modest improvements that we continue to achieve, it is difficult for us to make giant gains within some of these measures considering the population that we serve. This inequity has ultimately created a disparity in critical revenue for many health plans that serve our nation's Medicare beneficiaries with the greatest needs. Below are some examples of measures where CareOregon has achieved significant improvement and high performance:

Improving/Maintaining Physical Health: We improved 3 percentage points from 2013 to 2014, and 8 percentage points from 2014 to 2015. We currently score at the5 star performance level for this measure.

Cardiovascular Care – CareOregon has improved from a 2 star score to a 4 star score for this measure.

Complaints about the Health Plan: CareOregon consistently scores high in this measure remaining at a 5 star level.

Getting Appointments and Care Quickly: CareOregon has been scored at 4 stars for the last two years.

Members Choosing to Leave the Plan: CareOregon members usually remain with our plan; we consistently receive a score of 5 stars for this measure.

Our Plan Finder Price Accuracy: This measure consistently performs at 4 stars.

Below are some examples of measures where CareOregon achieved significant improvement, but insufficient improvement to merit a bump in our star rating score:

Colorectal Cancer Screening: This measure improved by 5 percentage points from 2014 to 2015, yet the improvement was not sufficient for an increased star score. We are currently scored at 3 stars for this measure.

Adult BMI: There has been significant improvement in this measure year over year. We improved by 7 percentage points in 2014, and then improved by another 6 percentage points in 2015. Yet, when our improvements are curved against health plans that do not serve a similar population, CareOregon gets penalized. In this measure we declined from a 4 star position in 2013 and 2014 to 3 stars in 2015.

Treatment in Rheumatoid Arthritis: CareOregon experienced an 8 percentage point increase from 2014 to 2015; yet this improvement was insufficient for an increased star score. This measure remained rated at the 4 stars.

Reducing the Risk of Falling: CareOregon improved by 6 percentage points from 2014 to 2015, but our star rating score remained at 4 stars.

Overall Rating of the Plan: CareOregon experienced a jump in CAHPS responses. This increase led to an improvement from a score of 2 stars to a score of 4 stars.

The significant improvement within scoring measure was the direct result of intensive coordinated effort was executed at the end of 2013. CareOregon selected measures for improvement which balanced the desire for large improvements with our need to efficiently target our limited resources. Keeping this balance in mind, CareOregon has invested in transitional care and continues to foster partnerships with hospitals and discharge planners in an effort to improve our score within the readmissions measures. Through evaluation of our successes in past efforts, and in consideration CareOregon's MA-PD population, we feel that a readmissions improvement effort would require a complete overhaul of our model of care. Furthermore, the challenge may be so significant that a complete overhaul of our care model may not result in a 4 or 5 star improvement.

We worry about the effect of payment reductions on some of our supplemental benefit options. For example, a new supplemental over the counter (OTC) benefit, introduced in contract year 2014, has been extremely popular with members. We initially believed that supplemental benefits such as this might translate into a better rating within the member plan rating measure. However, our ability to maintain a supplemental benefit with negative margins is counterintuitive to a viable business model. CareOregon's dilemma, also connected to the nature of the population we serve, is that many of our member's basic needs are not being met. We work to produce supplemental benefits to address needs intrinsic to the population we serve; however, we often receive little credit for these innovations within the current star rating system. In the current environment that penalizes health plans for operating outside of the structure of what the star rating system can (and cannot) measure, what was once a clear win-win benefit for our membership and CareOregon may ultimately turn into a lose-lose proposition for our membership and our ability to innovate.

Below are examples of measures where high performance was achieved and maintained, but due to the bell curve utilized by the star quality rating system, CareOregon's star score declined:

Part-D Medication Adherence for Hypertension: CareOregon has continued to perform at the same level within this measure, but we were most recently rated down to 3 stars due to the impact of national improvement in this measure and that effect on the curved scoring.

Part-D Medication Adherence for Cholesterol: similar to the fate of adherence for hypertension, CareOregon also declined from 4 stars to 3 stars in spite of our consistent performance.

Below are measures where we consistently underperform:

All Cause Plan Readmissions: As previously mentioned, we do not think CareOregon can achieve high performance in this measure without a major overhaul of our model of care coupled with commitments from the communities that support this population.

Overall Rating of Health Care Quality: CareOregon believes that we consistently perform low in this measure because it is a composite measure compiled and rated from six different questions and possible responses. As explained further below, we believe our population may have some trouble responding to these questions.

Ease of Getting Prescriptions Filled: CareOregon consistently performs at the 2 star level for this measure. Ongoing efforts continue to improve performance.

We have some concerns regarding the methods used to rate plans that serve low income populations. CAHPS measures are collected via an English only survey mechanism. This effectively excludes our non-English speaking sub populations from participating. Plans like ours have a more diverse population, and non-English speaking members' feedback is not being captured. Because duals experience care and receive communications from multiple programs (Medicaid & Medicare), we are concerned that members' responses to questions about their health plan are tainted with potential negative experiences that are out of the control of the plan. For example, the Medicaid eligibility process is managed by the state of Oregon, Long Term Care and Support Services are carved out and managed by the state, and our members may have dealings with Medicaid Coordinated Care Organizations that are not the same as their Medicare Advantage Prescription Drug Plan. These outside factors could have an impact on a member's perception of health care as a whole, and we think that CareOregon is often perceived as guilty by association.

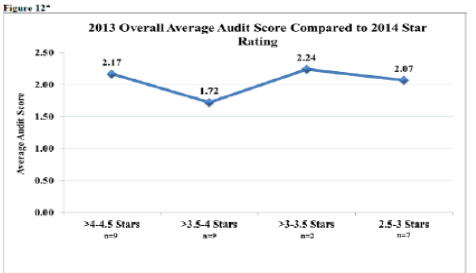
Finally, we are concerned that a health plan's star rating does not accurately correlate with how compliant the health plan is with current regulations and/or required performance measures. Furthermore, we do not believe that poor star performance is only attributable to poor plan administration. We believe that some plans with high star ratings could be out of compliance with current regulatory requirements as evidenced by the graph below, and we also believe that population can also be a factor to poor plan performance as demonstrated in the attached graph. We would advocate for better alignment between this star rating system and compliance.

No evidence that lower stars scores is caused by poor plan administration

THE Hypothesis that good audit scores are associated with high stars performance is not supported....

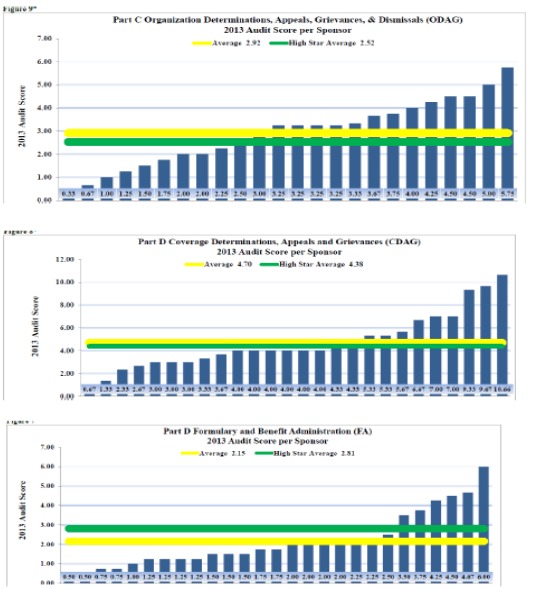
- There is no clear pattern that ODAG, CDAG and Formulary administration are associated with stars scores
- In other words, there is no evidence SNPs low scores for access are associated with poor administrative performance

Figure 12*



*Audit and star rating scores were analyzed at the sponsor (parent organization) level. A lower audit score represents better audit performance. A higher star rating represents better quality and performance.

WELLPOINT



Lower is better

Source: 2013 Part C and Part D Program Annual Audit and Enforcement Report. October 16, 2014