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MEDICA®

October 31, 2014

Department of Health & Human Services
Center for Medicare & Medicaid Services
Part C & Part D Star Ratings

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

To Whom It May Concern:

Medica appreciates the opportunity to comment on the Request for Information about the Impact of Dual Eligible Members on Plan Performance. Medica is a local, Minnesota based company that has been providing non-profit health coverage in the Midwest for more than 38 years. As a plan with both a Medicare Cost Plan and a Dual Eligible Special Needs Plan (D-SNP), Medica is in the position to compare and analyze plan performance in quality measures. Medica Prime Solution (H2450) is Medica's Cost plan, offered in Minnesota, western Wisconsin, North Dakota and South Dakota. Medica Prime Solution provides a range of affordable medical and Part D options that work with Original Medicare by covering important costs that Medicare does not. Medica DUAL Solution (H2458) is a D-SNP, offered in 33 counties in Minnesota in 2014. DUAL Solution began as a demonstration project in 1997 and was converted to a D-SNP in 2008. It is a fully integrated dual eligible (FIDE) type of D-SNP where the member receives one member card and all services and claims including Medicaid, Medicare, and Part D benefits are managed by Medica. Each DUAL Solution member is assigned a Care Coordinator. Care Coordinators are registered nurses or licensed social workers who perform assessment, care planning, and evaluation of members.

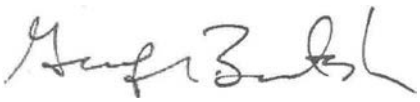
A review of the most recent Medicare Health Outcomes Survey (HOS) shows the distinct differences in the member demographics between these two plans. As compared to the Cost Plan, Medica's DUAL Solution members are older and more frail. Over 50 percent (51.7%) of the DUAL Solution members surveyed for the HOS survey are over 80 years old, as compared to 28.9% of Cost Plan members. Additionally, 52.3% of members surveyed have two or more impairments with Activities of Daily living,

as compared to 15.6% of members in the Cost Plan at Medica. Medica has completed a comparison of the plan performance of both the Cost Plan and D-SNP plans across several measures.

Medica has identified quality priorities to focus our quality improvement efforts in 2014 and 2015. Included in this work are projects related to Colorectal Cancer Screening, High Risk Medication Usage, and Osteoporosis Management in Women Who Had a Fracture. Efforts to improve these measures will include interventions with providers, Care Coordinators and members. Historically, Medica has shown success with quality improvement efforts that involve multiple interventions across providers, members and Care Coordinators. Medica will track the outcomes of these quality improvement efforts over time.

Attached you will find the analysis on the performance of the two populations completed by Medica comparing performance on five measures. The analysis shows that the differences in reported rates are independent of population differences in illness burden and service utilization, and are not likely to be a result of differences in quality of care. As such, Medica recommends that the dual eligible plans be measured against other dual eligible plans. This would allow for a more accurate benchmarking of quality performance measures.

Sincerely,



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Medicare Advantage D-SNP and Cost Plan Population Comparison Report

Request Details: Conduct an analysis comparing performance for Dual Eligible Special Needs Plan (D-SNP) and Cost Plan members on a variety of performance metrics. Perform routine analysis and additional analysis controlling for illness and utilization variables.

Data Sources:

Medica HEDIS 2014 submission data from Verisk Health
ACG.ACG_Final_T_Rolling_Yr_V9

Data Details:

HEDIS submission data for 2014, dates of service 2013
Measures evaluated:

- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART) DMARD Therapy – Rheumatic Therapy
- Breast Cancer Screening (BCS)
- Colorectal Cancer Screening (COL)
- High Risk Medication Usage (DAE)
- Osteoporosis Management in Women Who Had a Fracture (OMW)

Control variables were obtained from ACG (Johns Hopkins Adjusted Clinical Groups) run data from December of 2013 with 3 months run out
Populations were restricted to Medica Cost Plan and D-SNP members.
For hybrid measures only those selected for sampling were included in the analysis

Process:

Data for all measures were collected and initial rates were calculated. ACG scores were then added as control variables and t-tests were conducted to determine if the two populations differed on those variables. At this point members who were not able to match with ACG data were dropped and two statistical analyses were conducted, one without the control variables and one with the control variables. Given the nature of the data, in which a mix of continuous and categorical variables were being used as independent variables, it was determined that General Linear Modeling would be the most appropriate statistical technique. Additionally, since the outcome variables were binomial in nature, these analyses were conducted with a binomial distribution and using a logit-link function.

Control Variables:

The following measures were entered as control variables to control for differences in illness burden across populations. Doing so allowed us to better understand if the observed differences in rate between populations are due to illness burden or factors inherent to the two populations.

- Inpatient Stay Count
- Outpatient Visit Count
- Major Aggregated Diagnosis Group (ADG) Count
- Hospital Dominant Condition Count
- Chronic Condition Count
- Age at Year End

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Results

Table 1
Initial Rates for Selected Measures

		Cost Plan			D-SNP		
Measure Abbreviation	Measure Description	Denominator	Numerator	Rate	Denominator	Numerator	Rate
ART	DMARD Therapy - Rheumatic Therapy	[redacted]	[redacted]	89.2%	[redacted]	[redacted]	71.7%
BCS	Breast Cancer Screening	[redacted]	[redacted]	76.5%	[redacted]	[redacted]	57.8%
CDC	Eye Exam	[redacted]	[redacted]	78.4%	[redacted]	[redacted]	76.6%
	HbA1c Control <8.0%	[redacted]	[redacted]	70.86	[redacted]	[redacted]	68.7%
	LDL-C Screening	[redacted]	[redacted]	87.4%	[redacted]	[redacted]	85.7%
COL	Screening	[redacted]	[redacted]	55.6%	[redacted]	[redacted]	50.0%
DAE	1 or more High Risk Meds	[redacted]	[redacted]	11.0%	[redacted]	[redacted]	18.2%
	2 or more High Risk Meds	[redacted]	[redacted]	1.2%	[redacted]	[redacted]	3.4%
OMW	BMD Test or RX	[redacted]	[redacted]	17.1%	[redacted]	[redacted]	8.4%

*note: for DAE measures a lower rate indicates better performance

Initial Rates for all measures are shown in Table 1.

Table 2
Control Variables

	Cost Plan n = [redacted]		D-SNP n = [redacted]		
Variable	Mean	SD	Mean	SD	t-Test
Inpatient Stay Count	0.14	0.4	0.33	0.78	-21.98*
ER Visit Count	0.3	0.78	0.5	1.12	-16.48*
Outpatient Visit Count	16.68	16.35	29.58	34.73	-34.73*
Major ADG Count	1.33	1.37	2.14	1.56	-47.36*
Hospital Dominant Condition Count	0.16	0.55	0.4	0.88	-25.28*
Chronic Condition Count	3.87	3.01	5.93	3.47	-54.56*
Age at Year End	75.23	7.66	80.11	8.86	-50.67*
					* p < .0001

Means and standard deviations for all of the control variables are presented in Table 2. T-tests were then conducted to determine if any observed population differences were statistically significant. An evaluation of control variables found that, relative to enrollees in the Cost Plan, D-SNP members have significantly higher inpatient utilization, emergency room utilization and outpatient utilization, indicating that the D-SNP population is significantly more likely to use services across the board. Moreover, the D-SNP population was found to have significantly more ADGs, hospital dominant conditions, and chronic conditions than the Cost Plan population. The observed differences in utilization in concert with the observed differences in illness burden suggest that the D-SNP population is sicker

and as a result are more likely to utilize services than the Cost Plan enrollees. Finally, the D-SNP population was found to be approximately 5 years older on average than the Cost Plan population.

Table 3
Significance Test Results for All Measures

		No Control Variables		With Control Variables	
Measure Abbreviation	Measure Description	Standard Error	Wald Chi-Square	Standard Error	Wald Chi-Square
ART	DMARD Therapy - Rheumatic Therapy	0.2313	26.22*	0.2572	13.81*
BCS	Breast Cancer Screening	0.053	268.05*	0.058	363.17*
CDC	Eye Exam	0.1592	0.4	0.1726	2.41
	HbA1c Control <8.0%	0.1407	1.11	0.1514	0.57
	LDL-C Screening	0.195	0.61	0.2098	0.28
COL	Screening	0.038	35.7*	0.0399	138.17*
DAE	1 or more drugs	0.0305	378.5*	0.0333	167.23*
	2 or more drugs	0.0698	245.86*	0.0777	134.91*
OMW	BMD Test or RX	0.2256	11.79*	0.2366	9.47*
					*p<.05

Interpretation

Initial analysis found that enrollment was a significant predictor of rate for DMARD Therapy - Rheumatic Therapy, Breast Cancer Screening, Colorectal Cancer Screening, High Risk Medication Usage (DAE), and Osteoporosis Management in Women Who Had a Fracture (OMW). These results remained significant when the control variables were added.

Table 4 duplicates the initial rates presented in Table 1 for those measures where statistically significant differences were found.

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Table 4
Cost Plan > D-SNP

		Cost Plan			D-SNP		
Measure Abbreviation	Measure Description	Denominator	Numerator	Rate	Denominator	Numerator	Rate
ART	DMARD Therapy - Rheumatic Therapy	[redacted]	[redacted]	89.2%	[redacted]	[redacted]	71.7%
BCS	Breast Cancer Screening	[redacted]	[redacted]	76.5%	[redacted]	[redacted]	57.8%
COL	Screening	[redacted]	[redacted]	55.6%	[redacted]	[redacted]	50.0%
OMW	BMD Test or RX	[redacted]	[redacted]	17.1%	[redacted]	[redacted]	8.4%
DAE	1 or more drugs	[redacted]	[redacted]	11.0%	[redacted]	[redacted]	18.2%
	2 or more drugs	[redacted]	[redacted]	1.2%	[redacted]	[redacted]	3.4%

The finding that the observed differences remain significant in the presence of control variables suggests that differences in reported rates are independent of population differences in illness burden and service utilization. Therefore, performance differences are not likely to be a result of differences in quality of care and the two populations should be considered separate groups with independent distributions of expected rates. Based on these findings we can recommend that separate standards should be maintained for D-SNP and Cost Plan populations.