November 3, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Transmitted electronically via PartCandDStarRatings@cms.hhs.gov

Re: Request for Information Regarding Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees

Dear Administrator Tavenner:

Colorado Access appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Request for Information Regarding Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees. Colorado Access offers a Medicare Advantage (MA) Special Needs Plan (D-SNP) to individuals who are dually-eligible for Medicare and Medicaid. We believe all plans should be held accountable for quality measures and outcomes. However, the current Star Ratings methodology puts plans like ours at a disadvantage due to the unique characteristics of the dual-eligible populations. Dual-eligible members are then put at a loss when their plans do not receive accurate Star ratings and the accompanying reimbursements.

We commend the Agency's interest in understanding the disadvantage to MA plans with a disproportionate share of dual-eligible beneficiaries and how reforming the Star Rating methodology with socio-demographic adjustments will allow for alignment and accurate measurement. As we enumerate in our comments that follow, we encourage CMS to consider the extensive body of literature and reform the MA and Part D Star Rating quality measurement methodology to account for the underlying characteristics of dual-eligible enrollees.

Colorado Access Medicare Advantage Special Needs Plan

Founded in 1994, Colorado Access is a local, nonprofit health plan that offers a Medicare Advantage Special Needs Plan, "Access Advantage," to over 3,000 dual-eligible enrollees. The average age of Access Advantage membership is 59, 64% of which are under the age of 65 and qualify for Medicare due to serious health conditions, such as serious and persistent mental illness or SPMI. Based on 2013 medical claims, the top five clinical conditions for Access Advantage members are: respiratory disorders,

hypertension, diabetes, and mental health disorders which are predominately schizophrenia and depression. Within this membership, 44% have a mental illness diagnosis and the average number of prescriptions per member per year is 57. Interdisciplinary teams deliver unique services that include but are not limited to: home visits, after-hours availability, and assistance with accessing preventive care, home and community-based services, medication therapy management, dental services and transportation. Intensive care management is central for Access Advantage to effectively serve these high-need enrollees and assist with medication adherence.

Medication adherence is important both to managing chronic illnesses and good performance in the Stars system. Dual-eligible beneficiaries are often unable to afford even the lowest of prescription drug copays and, without care management, struggle with complex prescription drug regimes. The Access Advantage dual-eligible membership is not unique in its difficulties with medication adherence; existing research on dual-eligible enrollees finds significant disparities in medication adherence when compared to the non-dual population.

We understand CMS' preference for evidence of a causal relationship between dual-eligible status and lower performance on Star Ratings, but we and (we believe) others lack the capacity to perform a controlled trial when the key factor is socioeconomic status. **We strongly urge CMS to refrain from using the limited documentation of causality as an excuse to ignore the overwhelming body of evidence of disparities in health outcomes for the dual eligible population.**

Research on Dual-Eligible Enrollee Disparities

The following studies demonstrate the relationship between dual-eligible enrollment performance on specific quality measures.

- Sarah-Jo Sinnott, Claire Buckley, David O'Riordan, Colin Bradley, and Helen Whelton, "The Effect of Copayments for Prescriptions on Adherence to Prescription Medicines in Publicly Insured Populations; A Systematic Review and Meta-Analysis," *PLoS ONE* (May 28, 2013). http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0064914

This study analyzed non-adherence to prescription medications in populations who received public health insurance. When copayments are introduced or increased, non-adherence rates increased by 11% for publicly insured enrollees. Dual-eligible enrollees encounter unique vulnerabilities that make them more sensitive to unfavorable health outcomes. The impact of cost sharing on this distinct group can only be correctly assessed through targeted quality measures.

- Niteesh K. Choudhry, Katsiaryna Bykov, et al. "Eliminating Medication Copayments Reduces Disparities in Cardiovascular Care," *Health Affairs* Vol. 33 No. 5 (May 2014).

http://scholar.harvard.edu/files/nkc/files/2014_impact_of_copayment_reductions_on_cv_disparities_health_affairs.pdf

Published in *Health Affairs*, this study reported similar findings as Sinnott et al in looking at the relationship between copayments and disparities in cardiovascular health. Researchers found that racial and ethnic minorities make up a larger proportion of vulnerable patients and eliminating economic barriers improved clinical outcomes and cost containment efforts. Plans with a disproportionate number of dual-eligible enrollees must offer benefit designs tailored for these beneficiaries and apply evidence-based interventions that differ from those of non-dual-eligible beneficiaries.

- Weiss, H. & Pescatello, S., "Medicare Advantage: Stars System's Disproportionate Impact On MA Plans Focusing On Low-Income Populations," *Health Affairs* (2014). http://healthaffairs.org/blog/2014/09/22/medicare-advantage-stars-systems-disproportionate-impact-on-ma-plans-focusing-on-low-income-populations/

This analysis of the star measures concluded that plans with a large share of low-income members score lower on individual measures such as medication adherence. While new models of care coordination improved outcomes in 2013 and 2014, the plans with dual-eligible enrollees consistently expressed lower levels of expected satisfaction.

- Inovalon, Inc., "An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures," (2014). (Attached)

A recently released study conducted by the Inovalon Group reports that dual-eligible enrollees performed lower on 10 of the 18 measures and 6 of the 8 current Star measures in the group evaluated. The study found dual-eligible enrollees scored lower than non-duals on medication management, with particular challenges in the context of behavioral health conditions.

Colorado Access encourages CMS to revise its methodology through the inclusion of socio-demographic adjustments to select measures such as medication adherence and patient experience in order to correctly assess plan performance. Individuals living with serious mental illness have a higher risk of chronic medical conditions, increasing the need for care coordination to help them manage these comorbidities and necessary medications.[1]

[1] Colton, C.W. & Manderscheid, R.W., "Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states," *Preventing Chronic Disease: Public Health Research, Practice and Policy*, 3(2), 1-14 (2006).

Accounting for comorbidities and socio-demographic barriers will allow for apples-to-apples comparison of plan performance. In addition, dual-eligible individuals report different experiences than those who are solely enrolled in Medicare. These issues include but are not limited to: the lack of continuous eligibility/churn, provider resistance to participating in the Medicaid program, and lack of access to social supports such as housing, nutrition, and transportation. While Colorado Access strives for higher plan satisfaction, access and improved clinical outcomes, these factors are not within our control and impact strongly on enrollee experience. Macro-environmental factors, such as Health Professional Shortage Area classifications and provider mix, should also be incorporated into the case mix for metrics relating to provider access.

In closing, we appreciate your efforts to reduce disparities and increase plan accountability, and your consideration of our comments. Should you have any questions or if we can be of assistance to CMS in this regard, please do not hesitate to contact Rebecca Kurz, Legislative Liaison, at Rebecca.Kurz@coaccess.com. Thank you again for the opportunity to comment on this important matter.

Sincerely,

Gretchen McGinnis
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Colorado Access
Access Management, LLC