November 3, 2014

Patrick Conway, MD, MSc
Deputy Administrator for Innovation & Quality, Chief Medical Officer
Center for Medicare & Medicaid Services
PartCandDStarRatings@cms.hhs.gov

Dear Dr. Conway:

Thank you for the opportunity to respond to your request for information on data differences in Medicare Advantage and Part D Star Rating Quality Measurements for dual-eligible versus non-dual eligible enrollees. NCQA understands that duals and others with low socioeconomic status (SES) sometimes have poorer outcomes which may be due to factors outside healthcare.

However, having large numbers of dual enrollees does not necessarily *cause* lower performance. In fact, our analyses find very little correlation between the plans' percentage of duals and NCQA's health plan rankings that Consumer Reports publishes. Like Star Ratings, our health plan rankings derive primarily from performance on several Healthcare Effectiveness Data & Information Set (HEDIS®) and Consumer Assessment of Health Plans Survey (CAHPS) results.[1]

For example:

- In Appendix 1, Figure 1 shows that Medicare Advantage plans with high duals enrollment (75% or more) have approximately the same distribution of performance as other Medicare Advantage plans. Figure 2 shows that there is only a very slight, not statistically significant tendency for lower performance with increasing percentages of dual enrollment.
- Appendix 2 shows that there are Medicare Advantage plans in every HHS region with high duals enrollment and NCQA Health Plan Rankings near or above the national median score of 66.

Specific measures included in MA Star Ratings shows similar results. For example:

- In Appendix 3, Panel (a) shows that plans with more duals *on average* have slightly worse blood sugar (HbA1c) control in diabetic patients. However, some plans with large dual enrollments get good results, while some of the worse performing plans have virtually no dual eligible enrollees.
- In Appendix 3, Panel (b) shows that blood pressure control for patients with diabetes is not meaningfully different between plans with a high versus low percentage of dual enrollment.

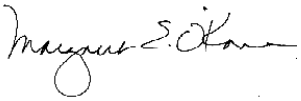
Together these analyses show that there is often no relationship between dual enrollment rates and plan performance. When there is an *association* between dual enrollment rates and plan performance, it is small and not a reliable predictor of poor performance.

[1] HEDIS® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Clearly many plans and providers serving duals achieve good results despite challenges that socioeconomic factors may present. That is why we oppose risk adjusting performance measures, as explained in our comments to the National Quality Forum, include in Appendix 4.

Thank you for the opportunity to share our findings and perspective. If you have any questions, please contact Paul Cotton, Director of Federal Affairs, at 202 955 5162 or cotton@ncqa.org.

Sincerely,



Margaret O'Kane,
President

Appendix 1

Figure 1(a) shows NCQA Health Plan Ranking (HPR) scores by HHS region for all MA contracts, while Figure 1(b) shows HPR scores for MA contracts with at least 75% duals enrollment.

Together they show that there is approximately the same distribution of performance among plans with high rates of duals enrollment as all others.

Figure 1

(a) All MA Contracts, HEDIS Year 2012

(b) MA Contracts with at least 75% Dual-Eligible members, HEDIS Year 2012

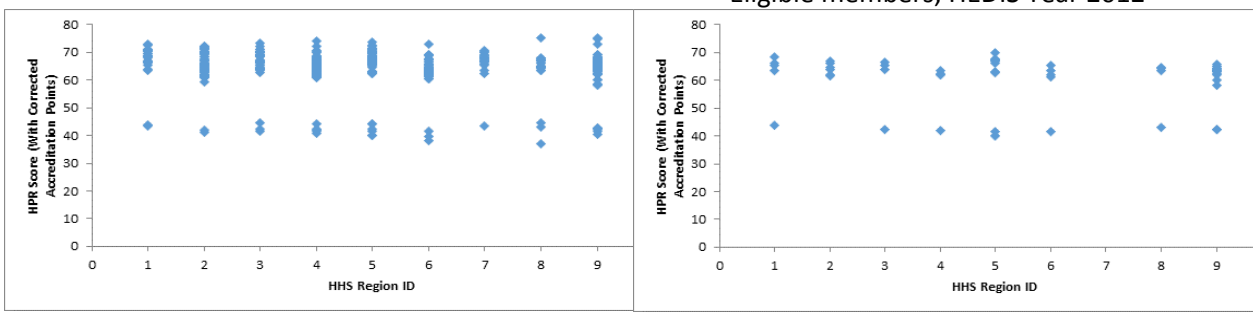
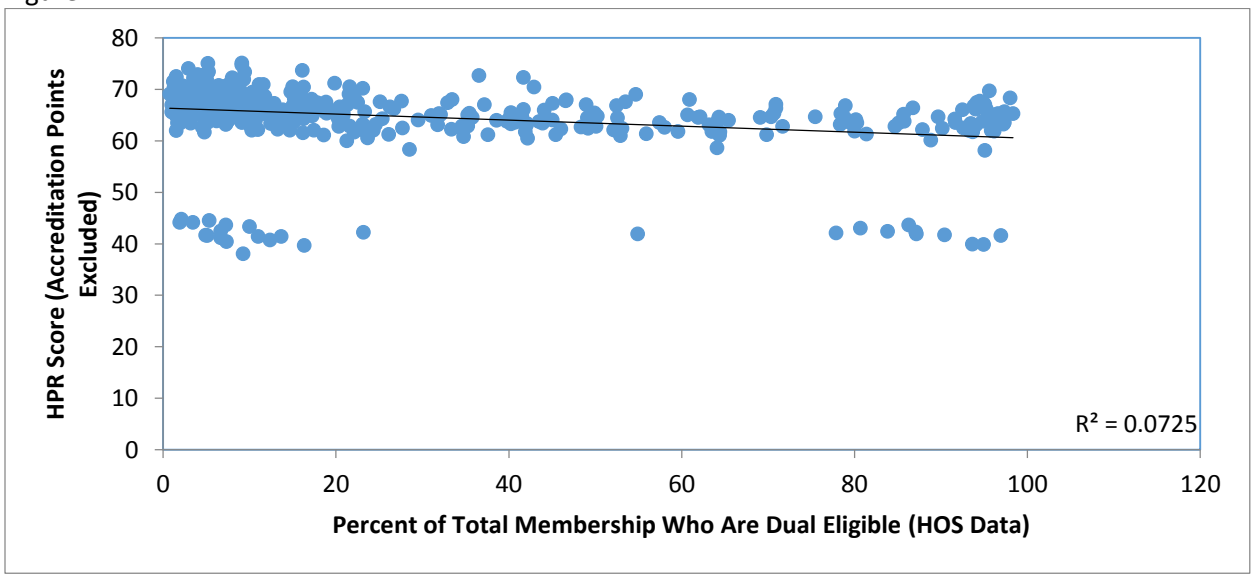


Figure 2: NCQA Health Plan Recognition Score (not including points for NCQA Accreditation) by percent of total duals enrollment.

The scatter plot shows only a very slight, not statistically significant tendency for lower performance with increasing percentages of dual enrollment.

Figure 1



Appendix 2: Medicare Advantage plans with at least 75% dual eligible enrollment and their NCQA Health Plan Ranking scores, not including points for NCQA Accreditation.

This shows that MA plans with high dual eligible enrollment rates in every HHS region earn NCQA Health Plan Rankings near or above the national median score of 66. Dual enrollment percentages are derived from Health Outcomes Survey Data, Cohort 14 Baseline.

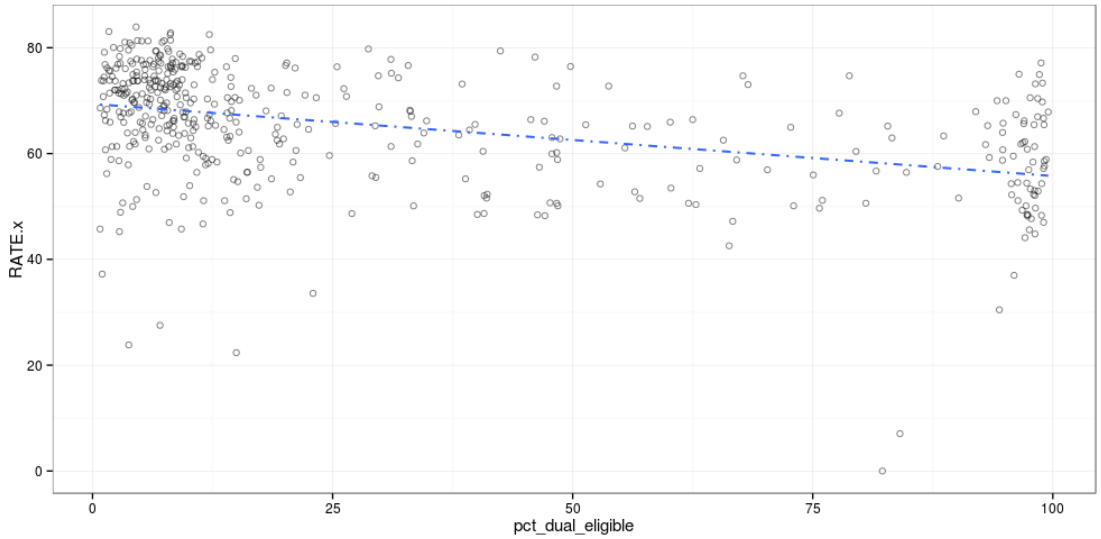
Organization Name	Total Membership	HPR Score	Percent Dual Enrollees	HHS Region
Commonwealth Care Alliance	3144	68.305	98	1
UnitedHealthcare Insurance Company - MA SCO	5587	66.1166	94	1
Senior Whole Health, LLC	6979	65.2885	98.3333	1
UnitedHealthcare Insurance Company -Connecticut	3916	63.541	91.6667	1
MetroPlus Health Plan	5083	66.8094	78.9167	2
Affinity Health Plan	3113	65.9904	92.5	2
PMC Medicare Choice, Inc.	45632	64.6403	75.4515	2
Medical Card System, Inc.	55961	63.7933	94.8333	2
UnitedHealthcare of New York, INC	4015	61.9947	93.25	2
AmeriChoice of New Jersey, Medicaid Managed Care Operations	4793	61.7019	93.6667	2
UnitedHealthcare Insurance Company –PA Evercare	1991	66.4136	86.75	3
Gateway Health Plan, Inc.	27666	65.4136	96.5833	3
AMERIGROUP Maryland, Inc.	1407	63.6893	95.8333	3
AMERIGROUP Tennessee, Inc.	1706	63.438	85.1312	4
UnitedHealthcare Insurance Company - Georgia (Medicare)	4979	62.4037	90.1667	4
AMERIGROUP Florida, Inc.	2228	62.1469	87.8767	4
UnitedHealthcare Plan of the River Valley, Inc., Medicaid Managed Care Operations	22202	61.8718	96.1667	4
Partnership Health Plan, Inc.	1478	69.7149	95.5833	5
Blue Plus (HMO Minnesota dba Blue Plus)	10045	67.7185	94.5	5
South Country Health Alliance	1794	67.4718	94.1667	5
HealthPartners	2963	67.3136	94.9167	5
PrimeWest Health	2140	67.0347	95.0833	5
Medica	9966	66.7799	93.8333	5
UCare	9179	66.0629	95.25	5
Independent Care Health Plan	4289	63.2496	97.2447	5
Molina Healthcare of Michigan	7215	62.7669	84.6667	5
Physicians Health Choice of Texas LLC	28636	65.2529	78.4062	6
UnitedHealthcare Insurance Company New Mexico (Medicare)	1397	63.3476	93.4669	6
AMERIGROUP Community Care of New Mexico, Inc.	1917	61.827	80	6

AMERIGROUP Texas, Inc.	9609	61.2702	81.3906	6
Molina Healthcare of Utah Inc.	7231	64.5085	78.8333	8
UnitedHealthcare of Colorado, Inc.	2234	64.0604	80.1667	8
Colorado Access Health Plan	3184	63.4734	80.25	8
Partnership HealthPlan of California	6584	65.6569	97.3333	9
Orange County Health Authority - dba CalOptima	11816	64.9981	96.5833	9
The University of Arizona Health Plan	2462	64.994	96.1667	9
SCHN/ Mercy Care Plan	15890	64.2338	96.9167	9
Health Choice Arizona, Inc. dba Health Choice Generations	4275	64.0938	97	9
Abrazo Advantage Health Plan	2643	63.7706	85.75	9
Alameda Alliance for Health	3805	63.5976	95.8333	9
Arizona Physicians IPA, Inc. Medicaid Managed Care Operations	22745	63.5404	97.3333	9
ONECare by Care1st HealthPlan Arizona	1549	63.4239	96.1667	9
Universal Care Inc., dba Brand New Day	1900	63.1546	78.3333	9
Health Plan of San Mateo	8187	62.9648	94	9
Advantage by Bridgeway Health Solutions	1850	62.4821	92.5833	9
Inland Empire Health Plan	5298	61.9504	95.8333	9
Trillium Community Health Plan	3190	65.1707	85.6667	10
Marion Polk Community Health Plan Advantage	3224	64.9315	97.25	10
UnitedHealthcare Insurance Company (Washington)	2320	64.6663	89.6667	10
Health Plan of CareOregon	6512	64.1954	91.5833	10
ATRIO Health Plans, Inc.	1982	64.0089	96.75	10
Molina Healthcare of Washington, Inc.	4037	63.5275	79.5	10

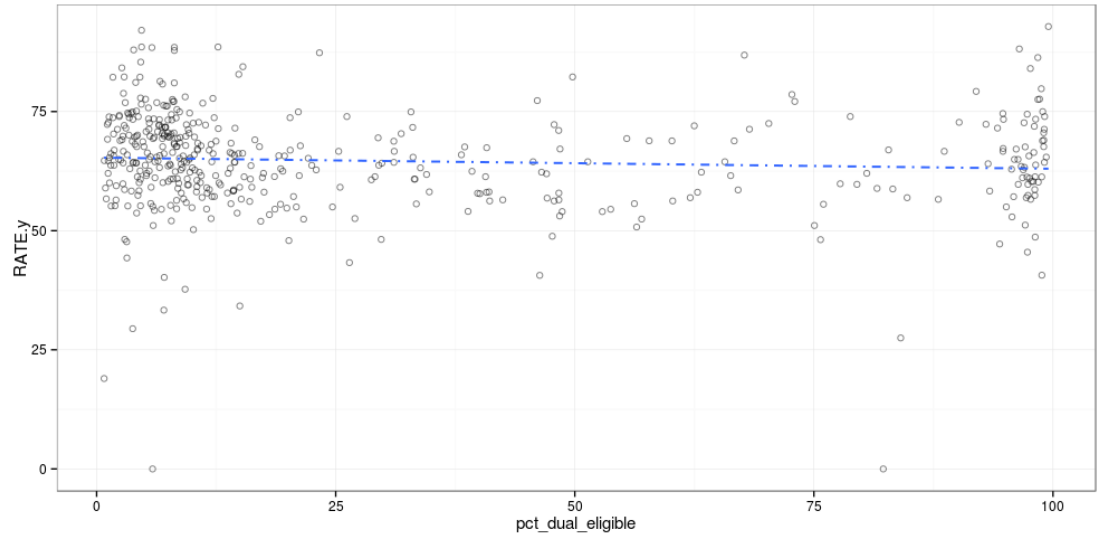
Appendix 3: The scatter plot in Panel (A) shows a slightly worse blood sugar control in diabetic patients. However, some plans with large dual enrollments get good results, while some of the worse performing plans have virtually no dual eligible enrollees.

The scatter plot in Panel (B) shows no difference between plans with high or low percentages of dual enrollments in the control of blood pressure for patients with diabetes.

(A) Control of HbA1c to less than 8%



(B) Control of blood pressure to less than 140/90



Appendix 4: NCQA Comments to the National Quality Forum on Socioeconomic Risk Adjustment.

April 16, 2014

Christine Cassel, MD
President & CEO
National Quality Forum
1030 15th Street NW, Suite 800
Washington, DC 20005

Dear Dr. Cassel:

Thank you for the opportunity to comment on your *Risk Adjustment for Socioeconomic Status or Other Socio-demographic Factors* report. We know many stakeholders have interest in risk adjusting outcomes measures (and select process measures) for socioeconomic status (SES) or other sociodemographic factors. There also is no doubt that improving care for the most vulnerable members of society is a primary aim of risk adjustment proponents.

Risk adjustment proponents note that people with lower SES often have poorer outcomes which may sometimes be due to factors outside of healthcare. As payments are increasingly based on outcomes like readmissions, they worry that lower payments that result from poorer outcomes will make it even more difficult to provide good care.

However, SES risk adjustment at the individual measure level would unfairly lock in lower expectations for the very populations that most need better quality. It is simply wrong to deny lower SES populations the right to expect and receive high-quality care. There are much better ways to address concerns of providers serving lower SES populations without risk adjusting away very real differences in outcomes.

Instead of lowering the bar on measurement to mask disparities for lower SES patients, we should work to ensure that providers have the resources and skills to meet these patients' needs. Person-centered, culturally appropriate care has been shown to reduce income-based disparities in care.[i] In addition, some providers serving low SES populations, such as Denver Health, have consistently outperformed many non-safety net providers. Since good outcomes clearly are possible in lower SES populations, we should not be excusing providers for poor outcomes that result from a lack of person-centered, culturally appropriate care.

Better methods to address SES-related disparities that do not skew measurement results include:

- Directly enhancing payments to providers serving low SES populations, based on SES-related data such as patients' zip codes or census tracts, so they have resources needed to address disparities;
- Sharing best practices of providers who achieve good outcomes in lower SES populations;

- Stratification of results by payer (Medicaid/CHIP, Exchanges, Commercial, Medicare) in ways that do not mask important differences that urgently need to be addressed; and

- Rewarding providers for a combination of absolute performance and quality improvement.

We also are concerned about unintended consequences of other provisions in the report.

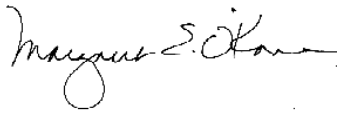
- The recommendations would require measure developers to "prove the negative" by showing that there is not a relationship between SES status and outcomes. This would be difficult if not impossible in far too many circumstances and is simply not practical.

- The recommendations also suggest that NQF expand its role to issue guidance to payers on how to implement measures. This could inhibit innovation among payers in developing new ways to combine measurement and payment policies to reward high quality care and improvement.

NCQA is nearing its 25th anniversary and our vision is to transform healthcare quality through measurement, transparency and accountability. Risk adjustment for SES and sociodemographic factors at the measure level will impede our progress by artificially reducing variation in performance measurement, putting a filter over the bright light of transparency, and lowering the bar of accountability. We are committed to closing gaps in quality through measurement but the measures must tell true stories, no matter how uncomfortable the finding.

Thank you again for inviting our comments. If you have any questions about our thoughts, please contact Mary Barton, MD, Vice President for Performance Measurement, at barton@ncqa.org or 202 955-5109.

Sincerely,



Margaret O'Kane,
President

[i] Berenson, J et al, Achieving Better Quality of Care for Low-Income Populations: The Role of Health Insurance and the Medical Home for Reducing Health Inequities, Commonwealth Fund, May 2012.