AzAHP
Arizona Association of Health Plans

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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*

On behalf of the Arizona Association of Health Plans ("AzAHP"), representing the companies who contract with the Arizona Health Care Cost Containment System ("AHCCCS") to provide for the health care needs of Arizona's most vulnerable citizens, we write in response to the Center for Medicare and Medicaid Services ("CMS") request for information regarding what we view as the fundamentally unfair treatment of the Dual Special Needs Plan ("D-SNP") model for beneficiaries dually eligible for Medicaid and Medicare in the CMS Star rating program.

Nationally, dually eligible beneficiaries account for $300 billion in annual spending by Medicaid and Medicare. D-SNP plans exist within the framework of Medicare Advantage ("MA") Plans. Dually eligible beneficiaries must apply for Medicare, with its one-size-fits-all rules and regulations, and also apply for state Medicaid benefits. It's a byzantine process: Beneficiaries are forced to navigate both systems to receive needed services and benefits. In many cases, the two systems are incompatible, and the beneficiary is caught in the middle of conflicting regulations and their needed care.

The program is called "Special Needs" for a reason: The enrollees have complex health care issues. In Arizona, dually eligible beneficiaries in our D-SNP plans are, in many cases, served by the same AHCCCS health plans that provide their medical and long-term care needs. These are our most frail, at-risk and diverse populations. 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 mental illness; they are candidates for institutionalization, frequently with severe and debilitating chronic conditions, including Alzheimer's, diabetes and heart disease.

D-SNP beneficiaries in Arizona receive integrated and coordinated care that is specifically and individually designed to meet their unique special needs. Beyond their incredibly complex health care provided during doctor's visits and hospital admissions, our D-SNP beneficiaries in the ALTCS program have case managers and caregivers who work to keep them in their homes and apartments, organize meals and provide transportation, manage their medications, meet with their families, and help them navigate enrollment in two federal programs.

Our model works. Medicaid plans in Arizona have the lowest drug costs in the Nation, not because we withhold care but, rather, because we effectively use generic and lower cost drugs. An Avalare Health study of D-SNP members in one of Arizona's plans – Mercy Care Plan – vs. a national model showed impressive results:

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

Yet, despite our innovation and 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. This is not about a website or health insurance for the middle class. It is a $300 billion (and growing) expenditure from Medicare and Medicaid to provide care for America's most vulnerable citizens.

We believe that the Star ratings system as currently applied for the MA program – which is intended to allow 4 and 5 Star Medicare Advantage Plans to receive added compensation in the form of Quality Bonus Payments and Rebate Retention Allowances for quality health care outcomes, but withholds any such payment for plans receiving fewer than 4 stars – actually harms plans that enroll dually eligible beneficiaries, the people who are most vulnerable and most in need.

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 policy makers 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. This issue was the subject of a recent study currently making news that is only the most recent in a series of studies that call into question the fairness and appropriateness of CMS's Plan Ratings System in determining the relative quality of health plans serving predominantly dual eligible populations.

In the largest industry analysis to date, Inovalon, Inc. found that plans with a higher number of dual eligible beneficiaries have a lower Star rating than MA plans with fewer dual eligible beneficiaries. Essentially, Inovalon found that it is the makeup of the underlying population in the plan – their income, race and ethnicity, age and gender – that drives a higher rating, rather than the performance and achievement of a health plan. As a result, the Star ratings system, as currently applied for the MA program, harms plans that enroll predominantly beneficiaries with Medicare and Medicaid eligibility through an unfair grading system that applies systematically lower Star ratings to dual eligible programs for reasons other than plan performance. (Inovalon's results are consistent with studies previously commissioned by Amerigroup's Public Policy Institute – "Are MA Star Ratings Biased Against Plans Serving Disadvantaged Populations?" – as well as quantitative research conducted by America's Health Insurance Plans ("AHIP").)

The *Health Affairs Blog* also looked at trends in the Star rating system from 2011 – 2014 and came up with the same conclusion, finding significant implications for the D-SNPs:

- Large differences in performance on the Star System between plans that focus on low-income populations and other plans are evident at the individual measure level across time.
- While average Overall Star Ratings are improving for all plans, the disparity between MA plans that focus on low-income populations and other plans is growing due to the unique challenges they face.
- Plan contracts that focus on low-income populations significantly underperform on the Star System compared to contracts with low enrollment of these beneficiaries.

medicare-advantage-stars-systems-disproportionate-impact-on-ma-plans-focusing-on-low-income-populations.

The reasons for this are clear. The Star ratings system grades all MA plans, regardless of dual eligible participation rates, on the same forced curve. As studies make clear, Star ratings directly correlate to the level of dual eligible participation in a plan. Thus, plans with little or no dual eligible membership consistently receive higher Star ratings, driven by risk factors associated with the underlying population rather than plan performance.

We strongly believe that factors other than plan performance should not be used to pick winners and losers in the Medicare Advantage program, particularly when it harms those plans that have the most relevant experience and consistently deliver high quality services in support of the most vulnerable, needy, and costly members of the Medicare population. Harming D-SNPs by making the business less viable (by withholding plan payments meant to compensate for deep cuts to base capitation rates) is detrimental to dual eligible

beneficiaries, because it takes funding directly out of supplemental benefits, such as dental, vision, hearing, wellness, etc., that directly improve the lives and the long-term health of dual eligible beneficiaries, since these benefits are not covered by original Medicare and are not consistently covered by Medicaid. In addition, driving experienced D-SNP plans out of the business would create a situation in which dual eligible beneficiaries, who, as a group, require a higher level of management due to their higher risk factors (higher disease burden, socioeconomic disparities, behavioral health conditions, etc.), would be either unmanaged or managed by traditional MA organizations, which are less equipped than D-SNPs to apply sufficient levels of care coordination to improve health status, control costs, and drive high levels of member satisfaction.

The solution, as we see it, may be as simple as establishing an apples-to-apples comparison of D-SNPs to serve as the basis for a quality evaluation. We support and endorse the efforts of the SNP Alliance, AHIP, and others in raising awareness of the structural inequity of the Star ratings system as applied to D-SNPs.

Specifically, and based on all of the available data, we encourage CMS to develop and apply structural changes to the system to correct the unintended consequences that harm plans serving predominantly dual eligible beneficiaries. Recommendations include:

1. Comparing or benchmarking D-SNP plans against other plans with similar types of enrollment, rather than against traditional MA plans;

2. Develop D-SNP-specific cut points and methodology for scoring D-SNPs more fairly;

3. Develop and apply appropriate case mix adjustments to HEDIS and HOS survey measures to account for factors beyond the control of the health system; and

4. Identify and implement measures that are more appropriate for the dual eligible population.

The current standards for D-SNPs combined into the Medicare Advantage regulatory world threaten the integration and system improvements state Medicaid programs (such as Arizona) have in place. Not addressing this issue is not an option for dual eligible beneficiaries that rely on us. These issues are very real for the 137,000 dual eligible beneficiaries in Arizona and the 9,000,000 nationally. We believe improvements to the Star rating system, as well as alignment of marketing and quality measures and additional authority for CMS to waive barriers, will allow for D SNPs and states to be innovative and effective in the delivery of services.

We are grateful for the opportunity to share our concerns with you on these critical issues at stake and sincerely appreciate your reaching out to the people on the front lines to share their expertise as you consider changes to the current system.

Very truly yours,

ARIZONA ASSOCIATION OF HEALTH PLANS, INC.

/s/ Deb Gullett
By:
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