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November 3, 2014

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

Submitted via e-mail to: 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 Ms. Tavenner:

Maricopa Care Advantage (MCA) Contract # H6623 greatly appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) in response to the *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.* MCA is Dual Special Needs MAPD and serves only full-benefit dual-eligibles under its contract with CMS. In the past, MCA has supported industry requests for CMS to re-evaluate its reimbursement structure to accurately account for the underlying characteristics of a plan's enrollees. We believe that the stars quality rating system, in its current form, disadvantages health plans that enroll full-benefit dual eligible populations, and we applaud CMS for issuing this RFI to gather more information on this important subject.

The correct assessment of plans' ability to serve the highly complex and disparate sub-populations of people enrolled in both Medicare and Medicaid, the dual eligibles, is a consumer as well as a plan issue. Duals lose when their plans do not receive accurate Star ratings and the accompanying bonus to share with their members in the form of supplemental benefits.

MCA appreciates CMS' acknowledgement of the work of the National Quality Forum (NQF) about the impact of socioeconomic status on quality ratings and we urge adoption of their overall recommendations. (www.qualityforum.org/risk_adjustment_ses.aspx)

CMS' REQUEST
The request is sweeping in that it asks for "research related to whether dual status **causes** lower MA and Part D measure scores." That is a standard not easily met.

MCA did not have the time or resources to conduct new research to respond to this request. And our plan does not have enrollment in both D-SNPs and traditional MA plans or contracts with Duals members to compare "enrollees in the same contract and/or plan for all contracts under a parent organization for the Star Ratings measures." However, the fundamental Stars approach has not changed since our industry representative the Association of Community Affiliated Plans (ACAP) first had a consultant look at the challenges faced by safety net plans comprised of all full - benefit dual eligible enrollees.

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In 2010, ACAP contracted with Ingenix Consulting to compile data and produce a report on the relationship between D-SNP enrollments and star ratings. ACAP used this data as the basis for a fact sheet on Stars they issued in 2012. Ingenix (now, Optum) analyzed 325 Medicare Advantage contracts, 28 of which served an exclusively D-SNP population. It analyzed 33 separate measures of quality and performed a regression analysis based on 16 variable plan characteristics, including plan tax status, number of years in the Medicare Advantage program and market share, among others – as well as the plan's percentage of D-SNP membership.

In that analysis, Medicare Advantage Special Needs Plans that exclusively served dual eligibles at that time were found to have an average overall star rating of 3.11, which is significantly lower than the average rating of 3.41 for plans that serve no dual eligibles. This stems largely from lower scores on measures of clinical quality. The Ingenix regression analysis found that high D-SNP enrollment was negatively correlated with 11 of 16 measures of clinical quality. For-profit tax status was another predictor of lower quality. High D-SNP enrollment was correlated with lower performance on 3 of 6 measures of consumer experience, and did not correlate with lower performance on measures of plan operations and administration.

Citing the higher proportion of enrollees with mental illnesses, cognitive limitations, housing and food insecurities, and lower socioeconomic statuses, the report found a clear connection between D-SNP enrollment and star ratings:

> As a result of serving this population DSNP performance scores are **negatively impacted by the same persistent historical disparities impacting the population. Thus, the Stars performance rating system scores provide information largely on member selection effects rather than on plan performance.** Dual Eligible Special Needs Plans (D-SNPs) that are innovative and effective in improving care may still be rated more poorly than plans that are not effective at improving care but that serve populations with greater intellectual, financial, and health resources.

Inovalon Study: Just this past week, the Inovalon group released the first part of their major analysis on the association of socioeconomic status (SES) and other factors with underlying poor quality performance of dual-eligible members in MA plans. The research, *An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures,* was conducted on behalf of other plans and associations. The initial phase reports on how duals differ on clinical, demographic, health and other socioeconomic factors from non-duals enrolled in MA plans and how those differences impact Stars performance. While we are not aware of the details of that study's design and how its data were selected, we urge careful consideration by CMS of their findings.

CMS should be the owner of this data and have the capacity to analyze it. MCA asks CMS to collect data from plans in a manner which would allow thorough analysis at the person level on disparities and plan performance by CMS, its sister agencies within HHS such as AHRQ and the peer-reviewed research community. While that data is assembled and studied, we think NQF's trial period on risk adjustment and stratification is a good approach.

RECOMMENDATIONS:

Adopt the NQF Recommendations on Risk Adjustment and Stratification

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We support NQF's approach to carefully recognize that because "healthcare outcomes are a function of patient attributes (including SDS) as well as the care received, and patients are not randomly assigned to units for healthcare services so that all units have the same mix of patients, **risk adjustment is essential to ensuring an "apples to apples" comparison when examining outcome performance** in real-world settings." In this report, the Expert Panel recommends that for comparative performance assessment sociodemographic adjustment is appropriate if certain conditions are met, and further that if a measure is adjusted for sociodemographic factors it must be specified for stratification so that any disparities are made visible. The report lays out the conceptual and methodological basis for this and other recommendations. The Panel also made specific recommendations for operationalizing potential sociodemographic adjustment, including guidelines for selecting risk factors and the kind of information to submit for measure review. Finally, the Panel recommended that NQF appoint a standing Disparities Committee.

Require Plans to Report at the Plan Benefit Package Level

CMS should require quality measurement at the plan benefit package and should stratify, where possible, results by full dual and partial dual status. ACAP has long advocated that CMS require all plans to report (and be reported on) at the "benefit package" level so that fair comparisons can be made in the Stars ratings system, bonuses paid appropriately so that potential enrollees can have all the benefits to which they are entitled and can be better informed about their plan options. It is time to take this step so that D-SNPs can be compared to D-SNPs.

Conduct Further Research on the Effect of Small Numbers, Exclusions and Lack of Exclusions from Measures

Highly specialized plans may have a concentration of members which are so different from overall MA plans that the effects of exclusions or the lack of exclusions in various measures can have a major impact on the plans' Star ratings. For example, some plans have up to 40% of member excluded from surveys because they do not speak English or Spanish; others have very high concentrations of people with dementia or other end of life conditions which may make certain preventive protocols inappropriate. D-SNPs are much more likely to have people over age 65 that entered Medicare as people with disabilities, especially mental illness, and their appropriate drug regimens may not fit guidelines for high-risk drugs in the elderly. Another example concerns appropriate use of the drugs used to treat rheumatoid arthritis (DMARD). Clinical evidence indicates these are contraindicated for people with a history of cancer, alcohol abuse or anemia. These factors are not exclusions for HEDIS because they are not felt by NCQA to not be common enough occurrences to affect the 95% confidence interval for the measure calculation. However, some duals plans do have enough members to justify exclusion on these factors.

Support and Finance QI Initiatives Which Can Reduce Disparities and Improve Health Outcomes

CMS should use the authority and funding granted to the Center for Medicare and Medicaid Innovation to test approaches of quality improvement which help D-SNPs address disparities and improve overall health. The Stars bonus system may actually underfund the plans facing the biggest "lift" to close care gaps. We have long urged a half-star increase in the final ratings to reflect the inadequacy of both the risk adjustment system used for payment and the lack of one for quality measurement.

Allow Easier Plan "Buy-Down" of Pharmacy Co-pays for Duals and LIS members

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Medication adherence is important both to managing chronic disease and good performance in the Stars system. Even though they are low, the drug co-payments in the Part D program imposed on full-benefit dual beneficiaries create an adherence challenge to those people and to the ratings for adherence by their plans. MA/SNP plans have been allowed to buy down the Part D co-pays only by offering them as a supplemental benefit which is applied in the bid calculation before the LIS subsidy which reduces the overall money available for benefits. In the duals demonstrations, the order of calculation is reversed which has allowed states and MMP plans to reduce or eliminate this co-pay. **Research demonstrates that co-payments, however minimal, decrease medication adherence. We think the drug co-pay for duals unduly affects the measurement of drug adherence in plans enrolling low-income members.**

The Rand Study on co-pays are well-known, but we refer you to Jonathan Gruber. *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond.* October 6, 2006. http://kff.org/health-costs/report/the-role-of-consumer-copayments-for-health/

We also suggest looking at more recent studies especially 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." May 28, 2013. http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0064914

This meta-analysis looked at populations who received public health insurance and the effect that the introduction or increase of copayments had on that population's health outcomes and showed an 11% increase in non-adherence to medicines in publicly insured populations where medicine copayments are necessary.

And, of particular relevance, please refer to: 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

This study, published in Health Affairs, looked at the relationship between copayments and disparities in cardiovascular care. The abstract reads as follows:

> Substantial racial and ethnic disparities in cardiovascular care persist in the United States. For example, African Americans and Hispanics with cardiovascular disease are 10–40 percent less likely than whites to receive secondary prevention therapies, such as aspirin and beta-blockers. Lowering copayments for these therapies improves outcomes among all patients who have had a myocardial infarction, but the impact of lower copayments on health disparities is unknown. Using self-reported race and ethnicity for participants in the Post-Myocardial Infarction Free Rx Event and Economic Evaluation (MI FREEE) trial, we found that rates of medication adherence were significantly lower and rates of adverse clinical outcomes were significantly higher for nonwhite patients than for white patients. Providing full drug coverage increased medication adherence in both groups. Among nonwhite patients, it also reduced the rates of major vascular events or revascularization by 35 percent and reduced total health care spending by 70 percent. Providing full coverage had no effect on clinical outcomes and costs for white patients. We conclude that lowering

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copayments for medications after myocardial infarctions may reduce racial and ethnic disparities for cardiovascular disease.

Use the Health Outcomes Survey to Assist With Stratification

In 2013, CMS implemented the Medicare HOS 2.5; the latest version of the HOS questionnaire. MCA believes that the demographic data available in the Health Outcomes Survey could be used to help stratify data. The data is available by Contract Number so, again, CMS would have to require reporting at the plan benefit package or require that Contract Number and plan benefit packages be aligned as per previous comments. If this alignment were done, then good demographic data would be available to help stratify results. Plans are given the data about how they differ significantly in a variety of factors, but we are not sure that these calculations are used either to risk adjust the survey data or otherwise stratify the results.

Questions regarding race, ethnicity, sex, primary language and disability statuses were updated to comply with standards established by the Affordable Care Act. There is also a question about educational level as well as a marker for "Medicaid" which we presume in this Medicare focused survey is equivalent to duals status. All of that data is now up to date and usable. Statistically significant results in these data fields should be recognized in determining performance in the Stars system.

Even with these adjustments, there are factors like homelessness and severe and persistent mental illness and/or substance abuse which are not collected and not recognized as a performance challenge.

Conclusion

Once again, MCA would like to commend CMS for its efforts to seek advice on this important topic. MCA supports the Stars quality rating system's goals — namely, efficient care which helps reduce disparities and increase plan accountability — but a reform to the status quo is necessary. For a rating system to be effective it must do more than simply reflect the underlying health status of populations enrolled in plans; it must recognize that the D-SNP population differs fundamentally from the rest of the Medicare Advantage population. Initiatives to improve quality and reduce disparity should reward plans which are enrolling and seeking to improve care for this vulnerable population. Accounting for that difference and promoting apples-to-apples comparisons will aid individual beneficiaries and their families, while simultaneously giving D-SNPs a fair chance in the star ratings system. MCA is prepared to assist the agency with additional information as needed. If you have any additional questions please do not hesitate to contact Rick Slaughter at (520) 874-5533 or at richard.slaughter@uahealth.com

Sincerely,

Richard G. Slaughter

Richard G. Slaughter
Vice President Medicare & Commercial Programs

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