America's Health
Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

TO: Centers for Medicare & Medicaid Services

FROM: Mark Hamelburg
Senior Vice President, Federal Programs

DATE: November 3, 2014

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

We are writing in response to the Request for Information (RFI) issued by the Centers for Medicare & Medicaid Services (CMS) regarding the Medicare Advantage (MA) and Part D Star Ratings of plans with a disproportionate share of dual eligible or Part D low-income subsidy beneficiaries. As discussed in more detail below and in separate analyses to be submitted by member plans with substantial low-income enrollments, these plans systematically receive lower Star Ratings on a range of measures even though studies show overall gains in scores achieved under the MA program and despite extensive efforts undertaken by many plans and their contracted providers to address the challenges of serving their low-income members. The sophisticated analyses plans are submitting, supported by descriptions of plan efforts to achieve performance gains, are strong evidence that low-income status is causing lower-than-appropriate Star Ratings. Given the important role that the Star Ratings System plays in the MA program after passage of the Affordable Care Act (ACA), this inherent bias against plans focusing on dual eligibles and low-income populations threatens MA and Part D plans' continued contributions to improving the health and wellbeing of these beneficiaries.

Background

The RFI is of significant importance to AHIP's member plans participating in the MA and Part D programs. Forty-one percent of MA enrollees have incomes of $20,000 or less[1] and dual eligibles are increasingly enrolling in the program, including Dual Eligible Special Needs Plans (D-SNPs) and other MA plans.

MA and Part D plans have demonstrated a commitment to meeting the unique needs of this portion of their membership. Low-income beneficiaries often face a range of socioeconomic and other challenges in accessing high quality health care. MA plans have increased the availability

[1] AHIP Center for Policy and Research, *Low-Income & Minority Beneficiaries in Medicare Advantage Plans, 2011*, (February 2013).

of coordinated care and employ a host of other strategies to deliver care and services to low-income individuals. These activities include assigning care and case managers to develop individual treatment plans, engagement with community-based organizations, and outreach activities to better identify an individual's primary residence in order to provide reminders of medical appointments. Member plan responses to the RFI will provide further examples detailing the practices they and contracted providers are using.

The Star Ratings System is comprised of a variety of quality and performance measures that utilize plan data to evaluate clinical care outcomes and processes and operational activities, and utilize survey data from beneficiaries to evaluate their experiences. Ratings on individual Medicare Part C and Part D measures are used to determine overall Part C and Part D performance scores, and an overall plan score. These measures are displayed on Medicare.gov to assist beneficiaries in making enrollment decisions. In addition, the ACA directs the agency to make quality bonus payments to organizations achieving an overall rating of at least four Stars. A higher rating also makes a plan eligible for a larger rebate amount, which must be used to provide additional benefits and/or lower costs for beneficiaries.

AHIP Research

As we have previously reported to the agency and in an article recently posted on the *Health Affairs* website[2], a multiyear analysis of MA plan performance from 2011 – 2014 demonstrates contracts focusing on low-income beneficiaries are systematically disadvantaged by the Star Ratings System. Findings from this analysis include:

- Low-income focused plans generally have achieved Overall Ratings of 0.5 star less than contracts without this focus. Our initial analysis of the 2015 Star Ratings posted by CMS indicates these patterns continue to exist (see charts below).

- 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 over time.

- These differences persist in an analysis of plan performance on individual measures. This discrepancy is most pervasive for HEDIS and CAHPS measures, as well as Part D Medication Adherence measures. For example, prior research on the medication adherence measures has shown they are highly dependent on a combination of factors outside health plans' control such as education, socioeconomic status, and health

[2] See *Medicare Advantage: Star System's Disproportionate Impact on MA Plans Focusing on Low-Income Populations*, posted on September, 22, 2014. Found at http://healthaffairs.org/blog/2014/09/22/medicare-advantage-stars-systems-disproportionate-impact-on-ma-plans-focusing-on-low-income-populations/

status[3],[4]. Similarly, CAHPS measures are based on surveys of patients, and responses to such surveys may also be influenced by challenges faced by low-income members.

Overall Rating	2011	2012	2013	2014	2015
0% D-SNP Contracts	3.44	3.48	3.59	3.74	**3.74**
1%-25% D-SNP Contracts	3.19	3.29	3.42	3.68	**3.82**
25%-50% D-SNP Contracts	3.02	3.03	2.98	3.19	**3.21**
50%-100% D-SNP Contracts	**3.13**	**3.11**	**3.01**	**3.24**	**3.26**
All Plan Average	3.31	3.34	3.43	3.61	**3.63**

Overall Rating	2011	2012	2013	2014	2015
1%-25% LIS Contracts	**3.48**	**3.53**	**3.66**	**3.78**	**3.83**
25%-50% LIS Contracts	3.05	3.02	3.05	3.38	**3.39**
50%-100% LIS Contracts	**3.06**	**3.08**	**3.04**	**3.24**	**3.26**
All Plan Average	3.31	3.34	3.43	3.61	**3.63**

An example that illustrates the challenges faced by MA plans focusing on low-income individuals is their performance on the three SNP-only measures that were included in the Star Ratings from 2011 - 2014. Generally, the results show continued improvement among Chronic-SNPs and Institutional-SNPs (see results for 0% D-SNP enrollment below) that has not been mirrored by D-SNP focused contracts. These findings suggest systematic differences in performance are present for low-income focused plans, even when compared to other contracts that concentrate on very vulnerable and complex patients.

[3] Young, Gary J. et al. "Socioeconomic Characteristics Of Enrollees Appear To Influence Performance Scores For Medicare Part D Contractors." Health Affairs, 33.1 (Jan 2014): 140-146.
[4] Holmes HM et al. "Ethnic Disparities in Adherence to antihypertensive medications of Part D beneficiaries." Journal of the American Geriatrics Society. 60.7 (Jul 2012): 1298-303.

SNP Performance	2013 Care for Older Adults – Medication Review	2014 Care for Older Adults – Medication Review	2013: Care for Older Adults – Functional Status Assessment	2014 Care for Older Adults – Functional Status Assessment	2013 Care for Older Adults – Pain Screening	2014Care for Older Adults – Pain Screening
0% DSNP Contracts	3.74	4.48	4.06	4.60	4.06	4.36
1%-25% DSNP Contracts	2.97	3.70	2.85	3.87	3.25	3.37
25%-50% DSNP Contracts	2.73	3.39	2.30	2.79	2.82	2.52
50%-100% DSNP Contracts	2.93	3.25	2.57	2.98	3.04	2.94
All Plan Average	3.03	3.56	2.83	3.40	3.22	3.17

We strongly believe low-income status and related factors are a major cause of these differences. Low-income populations are more likely to have complex medical needs that benefit from the care coordination and disease management MA plans provide. However, MA plan activities to address the unique needs of these individuals are often complicated by their living conditions, the greater occurrence of cognitive difficulties among these populations, cultural factors affecting receptivity to care, and other obstacles to care and service delivery. MA plans have employed numerous strategies to ensure the beneficiaries they serve receive the full benefit of the coordinated care they provide. However, despite these additional efforts, MA plans that focus on low-income populations are not seeing the impact of these investments reflected appropriately in their performance on the Star Ratings System. It is also important to note that the National Quality Forum (NQF) has found similar results when analyzing the impact of sociodemographic status on outcome performance measures for physicians, hospitals, and other healthcare providers[5].

CMS Request for Information

Despite the preponderance of evidence previously submitted to CMS that suggests the Star Ratings System systematically disadvantages low-income focused plans, the RFI challenged the

[5] National Quality Forum Technical Report, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*, (August 15, 2014).

industry to submit sophisticated analyses that demonstrate that the disproportionate share of low-income beneficiaries in plans causes lower Star Ratings, rather than lower quality care. To meet this challenge, CMS has indicated that the agency is looking for analyses that meet a variety of criteria, including comparisons of dual and non-dual (or LIS and non-LIS) enrollees in the same contract, and if possible multivariate analyses that meet tests for statistical significance.

We appreciate CMS has acknowledged that the November 3 deadline has given only a short time to complete robust analyses similar to research submitted for peer reviewed publication. That said, several of our member organizations have been working to provide studies that are as responsive as possible to this standard of rigor. Other organizations have data limitations that will not allow their submission to meet the level of statistical analysis that the RFI requests – for example, plans that solely focus on low-income populations and therefore do not have a comparison group. We understand they will be providing information about the strategies they have implemented as they have worked to overcome the obstacles described above.

The submissions will likely show low-income and other aspects of socio-economic status, as well as other related factors that play a material role in achieving Star Ratings performance. MA plans have a long history of demonstrating their commitment to the low-income populations they serve. Their experience strongly supports the need for changes to the Star Ratings System to account for these characteristics. Absent a significant change, there is a risk the quality-based payments put into place by the ACA will have the unintended consequence of discouraging organizations from focusing on low-income beneficiaries and reducing access to health plans' care coordination, focus on prevention, and emphasis on person-centered care for the vulnerable populations that need it most. For these reasons, it is critical that CMS take the necessary steps as quickly as possible to implement appropriate and meaningful changes to the Star Ratings System that are responsive to the issues raised above and in plan RFI submissions. We also urge CMS to provide a sufficient opportunity for plan review of any proposed changes to maximize the opportunity for the agency to receive informed and valuable feedback, for example, a comment period of at least 60 days.

AHIP and our member plans appreciate the opportunity CMS is providing to demonstrate further the impact of the Star Ratings System on low-income focused plans. We look forward to working with you to address the issues raised by these analyses and identify solutions that will strengthen the MA and Part D programs for the beneficiaries they serve. Please contact me if additional information about the issues we have raised would be helpful. I can be reached at (202) 778-3256 or mhamelburg@ahip.org.