

June 22, 2015

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

Dear Senators Isakson and Warner:

The undersigning health plans are focused on meeting the needs of the poorest and most chronically ill Medicare beneficiaries. As such, we applaud the Senate Finance Committee for forming a working group to determine ways to improve the care of Medicare patients with chronic conditions. We appreciate the opportunity to offer our thoughts regarding Medicare Advantage, an important option for beneficiaries with chronic care needs, including those who are dually eligible for Medicare and Medicaid,; economically disadvantaged Medicare beneficiaries eligible for low-income subsidies (LIS) under Medicare Part D; and in the case of Puerto Rico, (which has a much larger portion of its population that is disadvantaged medically, educationally and economically than the United States), those who *would* qualify for LIS if not for the territorial exception in the ACA which denies this critical support to MA populations in the territories.

The Medicare Advantage program fails to adjust either in payment or quality measurement for variations in education, health literacy, community resources, or experience with the health care system that many Medicare beneficiaries with low-socioeconomic status (low-SES) experience, particularly those who are dually eligible and have higher chronic care needs. As a result, a substantial bias has been created in the Star Ratings quality measurement program that must be corrected if the ratings are to accurately reflect the experience of members in a particular plan and thus serve as a reliable tool for beneficiary and regulator decision-making. **The purpose of this letter is to outline a short-term solution for Congress to consider that ensures that plans serving low-SES members are held accountable for quality while recognizing that it is imprecise to compare them with plans serving less disadvantaged members.**

There is a growing body of research that highlights the unique characteristics of dually eligible beneficiaries. Dual eligibles tend to be sicker, poorer, less educated, have lower health literacy, live in communities with fewer resources, and have more housing and income instability than non-dual eligible beneficiaries. This population tends to have higher chronic care needs -and as a result benefit greatly from coordinated care.

Comorbidity among dual eligibles is common. According to the Kaiser Family Foundation, dual eligibles are more likely to have:

- more than one physical condition (63% compared to 53% of non-dual eligibles);
- more than one mental/cognitive condition (20% compared to 5% of non-dual eligibles); and
- both a physical and mental/cognitive condition (38% compared to 17% of non-dual eligibles).¹

These challenges result in inherent inequities in the Medicare Advantage (MA) and Part D Star Rating methodology, a program used to rate MA and Part D plans, because “co-morbidity of physical and mental conditions increases care complexity and poses additional problems in coordination and access to needed services.”² In fact:

- 20.4% of dual eligibles report poor health status, compared to 7.28% of non-dual eligibles³;
- 34.45% of dual eligibles are diabetic, compared to 27.77% of non-dual eligibles⁴;
- 61% of dual eligibles have at least one mental or cognitive impairment, compared to 27% of non-dual eligibles⁵; and
- 19% of dual eligibles live in institutional settings, compared to 3% of non-dual eligibles.⁶

Dual eligibles with multiple chronic conditions rely more heavily on Medicare for hospital services and more frequently turn to Medicaid to provide long-term services and supports.⁷ We are including below a table comprised of data from the Centers for Medicare & Medicaid Services (CMS) showing the socio-demographic and functional status differences between dual eligibles and non-dual eligibles.

Demographic Factors of Dual Eligibles and Non-Dual Eligibles⁸

Factor	Dual Eligibles	Non- Dual Eligibles
Race/ Ethnicity		
White, non-Hispanic	55.88%	78.93%
Black, non-Hispanic	18.64%	7.90%
Hispanic	15.28%	8.62%
Other	10.20%	4.54%
Schooling		
0-8 years	24.60%	6.46%
9-12 years	21.04%	10.99%
High School Graduate	28.60%	28.05%
Voc/tech/bus/etc.	5.24%	7.50%
Some college	12.22%	17.85%
Any college degree	8.30%	29.15%
Income		
Less than \$5,000	9.56%	2.13%
\$5,000- \$9,999	39.48%	4.94%
Health Status		
Excellent	7.32%	18.41%
Very Good	13.37%	30.21%
Good	27.90%	27.97%
Fair	31.00%	16.14%
Poor	20.40%	7.28%
Functional Limitation		
None	20.93%	51.28%
IADL Only	17.21%	12.55%
One to two ADLs	29.14%	23.49%
Three to six ADLs	32.71%	12.68%
Chronic Conditions		
None	10.81%	8.51%
Diabetes	34.45%	27.77%
Pulmonary Disease	27.65%	18.07%
Stroke	13.77%	10.07%
Alzheimer's Disease	8.58%	3.74%
Living Arrangement		
Lives alone	31.22%	26.26%
With spouse	15.32%	54.84%
Long-Term Care Facility	13.48%	2.74%

Income

Income has a clear and profound impact on beneficiaries. For example, researchers have found:

- Rates of potentially avoidable hospitalizations were higher among low-income (income below 100% Federal Poverty Level [FPL]) households than high-income households.⁹
- Women from low-income households were less likely to receive a mammogram compared with women from high-income households.¹⁰

- The rate of hospital admissions for uncontrolled diabetes was higher for adults in low-income households than for adults in high-income households.¹¹
- Low-income adults were also less likely than high-income adults to take daily preventive asthma medicine.¹²
- Fifty-nine percent of dual eligibles have incomes below 100% FPL, compared to 9% of non-dual eligibles.¹³

Education and Health Behavior

Similarly, education and health literacy have a significant impact on health behaviors. According to the Robert Wood Johnson Foundation, “People with more education are likely to live longer, to experience better health outcomes... , and to practice health-promoting behaviors such as exercising regularly, refraining from smoking, and obtaining timely health care check-ups and screenings.”¹⁴ One study concluded that college graduates can expect to live at least five years longer than individuals who did not finish high school.¹⁵ Additionally, survey data shows adults with greater educational attainment are more likely to rate their health as very good.¹⁶ Data from the Medicare Current Beneficiary Survey shows that 45.64% of dual eligibles did not graduate from high school, compared to 17.45% of non-dual eligibles.¹⁷

Given disparities in educational attainment between dual eligible and non-dual eligible beneficiaries, and the correlation between low level of educational attainment and low income, health disparities, and unhealthy behaviors, the Star Ratings methodology should account for these differences in evaluating the performance of health plans that serve individuals with substantial chronic care needs including individuals who are dually eligible for Medicare and Medicaid; those near poverty who receive low-income subsidies (LIS) under Medicare Part D, and those who would qualify for LIS if not for the territorial exception in the ACA which denies LIS support to the territories.

While the Medicare Advantage program risk adjusts payment to account for comorbidities, it fails to adjust either in payment or quality measurement for variations in education, health literacy, community resources, or experience with the health care system that many low-income Medicare beneficiaries experience, particularly those who are dually eligible and have higher chronic care needs. As a result of this failure to adjust, a substantial bias has been created in the Star Ratings quality measurement program that must be corrected if the ratings are to accurately reflect the experience of members in a particular plan and thus serve as a reliable tool for beneficiary and regulator decision-making. Given the financial and enrollment impacts that the Star Ratings have on these plans, and the risk of contract termination that persistent low Star scores confer, it is likely that, unless a solution is implemented to correct the Star Ratings bias, such plans will be forced to exit the market, disrupting beneficiaries and limiting beneficiary choices.

While a long term solution is still years away and will require the completion of analysis currently under way at CMS, as well as data currently being collected by HHS as required under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014¹⁸, an immediate, short-term solution is required to ensure that plans serving low-SES members are held accountable for quality while recognizing that it is imprecise to compare them with plans serving less disadvantaged members.

To ensure that the care coordination and higher chronic care needs of this low-SES population are addressed properly, we ask that you consider a temporary solution that focuses on providing an adjustment for plans that take on the challenge of serving the neediest and sickest beneficiaries. For many months, the undersigned plans have carefully evaluated options to best address this inequity over the short term, and have recently coalesced around a single legislative solution. Outlined in the table below, this proposal would give plans serving high proportions of low-income members an opportunity to earn credit based upon improvement on a series of quality metrics known to be challenging when serving low-SES

populations. The adjustment would be granted based on both: 1) the proportion of low-income members who are (or would be, in the case of Puerto Rico) LIS eligible that is served by the plan; and, 2) the percentage of measures within the specified measure set upon which the plan achieved statistically significant improvement.

Short-term Star Ratings Proposal

	Statistically significant improvement on at least 25% but less than 30% of the measures within Part C Domains 1&2 and Part D Domain 4	Statistically significant improvement on at least 30% but less than 35% of the measures within Part C Domains 1&2 and Part D Domain 4	Statistically significant improvement on at least an 35% but less than 40% of the measures within Part C Domains 1&2 and Part D Domain 4	Statistically significant improvement on 40% or more of the measures within Part C Domains 1&2 and Part D Domain 4
20-34% of LIS Cohort	0.1 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.2 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.3 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score
35-49% of LIS Cohort	0.2 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.3 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score
50-74% of LIS Cohort	0.3 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score
75%-100% of LIS Cohort	0.4 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score	0.5 adjustment to the Overall Star Rating, Part C Summary, & Part D Summary Score

The measures we recommend in the calculation are those contained in Domains 1 and 2 for Medicare Part C, and those contained in Domain 4 for Medicare Part D. A table outlining those measures is below for your review. These measures were included based on both third party research and the responses to the recent Request for Information issued by CMS¹⁹, which showed that there are a number of clinical measures – the majority of which are included in these domains – that present a more significant challenge for plans serving beneficiaries of low socioeconomic status. The Part D Domain 4 was selected because plans with a high proportion of low-SES enrollees are at a substantial disadvantage on medication adherence measures since low-SES is correlated with poor medication adherence.^{20 21}

Measures Included in Star Rating Proposal

2015 Star Ratings Part C Domains 1&2, Part D Domain 4
Part C Domain 1-- Staying Healthy: Screenings, Tests, and Vaccines C01 - Colorectal Cancer Screening C02 - Cardiovascular Care – Cholesterol Screening C03 - Diabetes Care – Cholesterol Screening C04 - Annual Flu Vaccine C05 - Improving or Maintaining Physical Health C06 - Improving or Maintaining Mental Health C07 - Monitoring Physical Activity C08 - Adult BMI Assessment
Part C Domain 2 – Managing Chronic (Long Term) Conditions C09 - SNP Care Management C10 - Care for Older Adults – Medication Review

C11 - Care for Older Adults – Functional Status Assessment
C12 - Care for Older Adults – Pain Screening
C13 - Osteoporosis Management in Women who had a Fracture
C14 - Diabetes Care – Eye Exam
C15 - Diabetes Care – Kidney Disease Monitoring
C16 - Diabetes Care – Blood Sugar Controlled
C17 - Diabetes Care – Cholesterol Controlled
C18 - Controlling Blood Pressure
C19 - Rheumatoid Arthritis Management
C20 - Improving Bladder Control
C21 - Reducing the Risk of Falling
C22 - Plan All-Cause Readmissions

Part D Domain 4 – Drug Safety and Accuracy of Drug Pricing
D09 - MPF price Accuracy
D10 - High Risk Medication
D11 - Diabetes Treatment
D12 - Medication Adherence for Diabetes Medications
D13 - Medication Adherence for Hypertension (RAS Antagonists)
D14 - Medication Adherence for Cholesterol (Statins)

Using the existing Star Ratings methodology, statistically significant improvement from year to year on each measure would be calculated by CMS, and eligibility for and amount of the adjustment would be based on a contract's statistically significant improvement on the subset of measures and the contract's share of low-SES membership. The adjustment would apply to a plan's overall Star Rating as well as its Part C and D Summary scores. This temporary solution would continue to hold plans accountable for providing high quality coverage to low-SES members, while recognizing the substantial challenges that are present and which grow as a plan's share of low-SES membership increases.

We believe that this proposal will have the most universal impact while taking into account feedback we have collectively received throughout numerous interactions with Members of Congress and CMS over the past year and a half.

Thank you for this opportunity to share our policy recommendations to the Senate Finance Committee Chronic Care Working Group for your efforts to improve care for Medicare beneficiaries with chronic conditions. We appreciate your consideration of this proposal and would welcome the opportunity to provide any additional information you might require.

Sincerely,

Anthem
Centene Corporation
Cigna
Healthfirst
Innovocare
Molina
UPMC
WellCare Health Plans, Inc.

cc: U.S. Senator Orrin Hatch (R-UT), Chairman, Senate Finance Committee
U.S. Senator Ron Wyden (D-OR), Ranking Member, Senate Finance Committee

¹ Judy Kasper, Molly O'Malley Watts and Barbara Lyons, Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending, The Henry J. Kaiser Family Foundation Issue Paper, July 2010. Page 1. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8081.pdf>

² Ibid.

³ CMS. Medicare Current Beneficiary Survey, 2012. Characteristics and Perceptions of the Medicare Population, Table 8.5 Dual eligible data are collected from the "Medicaid buy-ins" column. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html?DLPage=1&DLSort=0&DLSortDir=descending>

⁴ CMS. Medicare Current Beneficiary Survey, 2012. Characteristics and Perceptions of the Medicare Population, Table 8.7 Dual eligible data are collected from the "Medicaid buy-ins" column. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html?DLPage=1&DLSort=0&DLSortDir=descending>

⁵ Kaiser Family Foundation. Medicare Chart Book, Fourth Edition. 2010. Page 53. <http://kff.org/medicare/report/medicare-chartbook-2010/>

⁶ CMS. Medicare-Medicaid Coordination Office Fact Sheet, "People Enrolled in Medicare and Medicaid," August 2011. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf

⁷ Ibid.

⁸ CMS. Medicare Current Beneficiary Survey, 2012. Characteristics and Perceptions of the Medicare Population, Tables 8.3, 8.5, and 8.7. Dual eligible data are collected from the "Medicaid buy-ins" column. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html?DLPage=1&DLSort=0&DLSortDir=descending>

⁹ AHRQ. National Healthcare Disparities Report. 2013. Page 193. <http://www.ahrq.gov/research/findings/nhqrdr/nhqr13/2013nhqr.pdf>

¹⁰ Ibid at 40.

¹¹ Ibid at 60.

¹² Ibid at 90.

¹³ Avalere: Blum, Jon, Lukens, Ellen, and Murphy, Lisa. (2007) Medicare Advantage Special Needs Plans/Six Plans' Experience with Targeted Care Models to Improve Dual Eligible Beneficiaries' Health and Outcomes, Prepared for the Association of Community Affiliated Plans. Page 4.

¹⁴ Robert Wood Johnson Foundation, Commission to Build a Healthier America, Issue Brief 5: Education and Health, April 2011: Exploring the Social Determinants of Health. Page 1. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwif70447

¹⁵ Ibid at 2.

¹⁶ Ibid.

¹⁷ CMS. Medicare Current Beneficiary Survey, 2012. Characteristics and Perceptions of the Medicare Population, Table 8.3 Dual eligible data are collected from the "Medicaid buy-ins" column. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html?DLPage=1&DLSort=0&DLSortDir=descending>

¹⁸ Improving Medicare Post-Acute Care Transformation Act of 2014, HR 4994 United States Code (2014).

¹⁹ Centers for Medicare and Medicaid Services. Request for Information Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollee. 2014; <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCAQFjAA&url=http%3A%2F%2Fwww.cms.gov%2FMedicare%2FPrescription-Drug-Coverage%2FPrescriptionDrugCovGenIn%2FDownloads%2FRequest-for-Information-About-the-Impact-of-Dual-Eligibles-on-Plan-Performance.pdf&ei=-xE1VLPEDofwGw4GoCA&usg=AFQjCNGaugz7tP0NZAbYnF-SrG99Q8Zn-A&sig2=oAOGyN2LTJiDiVolGs0hMA&bvm=bv.76943099,d.eXY>

²⁰ Young GJ, Rickles NM, Chou CH, Raver E. Socioeconomic Characteristics of Enrollees Appear to Influence Performance Scores for Medicare Part D Contractors. Health affairs (Project Hope). 2014;33(1):140-146.

²¹ Couto JE, Panchal JM, Lal LS, et al. Geographic Variation in Medication Adherence in Commercial and Medicare Part D Populations. Journal of Managed Care and Specialty Pharmacy. 2014;20(8):834-842.