ACAP
Association for Community Affiliated Plans

FACT SHEET

Medicare's Quality Incentive System Does Not Adequately Account for Special Needs of Dual-Eligible Populations

The Medicare Stars rating system for Medicare Advantage health plans was developed in an effort to help Medicare beneficiaries understand the quality of care delivered by their plans and to drive quality improvement through consumer choice. Each fall, Medicare Advantage plans are evaluated on clinical quality and patient experience[1] and given a rating of one to five stars. Plans with higher ratings could be presumed to be viewed more favorably by Medicare beneficiaries who are selecting a new plan.

The passage of the Affordable Care Act (ACA) raised the stakes by providing for a Quality Bonus Payment of three to five percent for plans with ratings of four stars or higher. In addition, the ACA tied plan rebates earmarked for extra benefits to a graduated scale based on performance ratings. Over the long term, this would make lower-performing plans less attractive to beneficiaries. CMS has opted to implement the bonus program by extending bonuses to plans earning three or more stars under the terms of a three-year demonstration announced in November 2010.[2]

ACAP supports health plan accountability, and related efforts to improve quality. But the Stars rating system as constructed has a substantial flaw: plans dedicated to serving "dual eligibles," persons eligible for both Medicare and Medicaid, are at a significant disadvantage compared with Medicare Advantage plans that serve the general population of Medicare beneficiaries. These plans dedicated to serving dual eligibles are known as Dual Eligible Special Needs Plans, or D-SNPs.

ACAP supports a model which has appropriate measures for the plan population and is either:

- Risk-adjusted to allow appropriate comparisons with other plans, *or*
- Compared only to other D-SNPs.

An accurate assessment of D-SNP performance would also include comparison with a matched cohort of dual eligibles in fee-for-service environments. A 2010 Ingenix Consulting analysis[3] of performance data gathered by the Centers for Medicare & Medicaid Services (CMS) suggests that plans dedicated to serving dual eligibles are operated as efficiently as non-D-SNPs; they perform at comparable levels on measures such as member complaints, timeliness of appeals and call wait times.

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[1] Medicare Advantage plans are rated through data collected through the Healthcare Effectiveness Data and Information Set (HEDIS®), the Consumer Assessment of Health Plans Survey (CAHPS) and the Medicare Health Outcomes Survey (HOS). Source: Medicare Payment Advisory Commission, "Current quality measurement systems in Medicare Advantage." http://www.medpac.gov/chapters/Mar10_Ch06_APPENDIX.pdf. Accessed November 7, 2011.

[2] http://edocket.access.gpo.gov/2010/pdf/2010-28774.pdf

[3] Ingenix Consulting. *The Medicare Advantage Stars Rating System and Dual Eligible Special Needs Plans: Is the Rating System Appropriate?* October, 2010.

But their overall performance scores lag because D-SNPs generally register lower HEDIS scores for clinical quality. This disparity in performance between measures of plan administration and clinical quality suggest that the health status of the underlying populations served by the plans heavily influence the overall star rating of D-SNPs.

The Association for Community Affiliated Plans (ACAP) represents 59 health plans in 26 states that serve, in aggregate, nearly 10 million Medicaid beneficiaries. Of the 59 ACAP-member health plans, 24 also operate a D-SNP. Despite ACAP's concerns with the Stars methodology, 16 ACAP SNP plans qualified for a bonus payment through earning at least three stars; five of these plans received four or more stars.

About Special Needs Plans

Special Needs Plans were created as part of the Medicare Modernization Act (MMA) of 2003 with an eye toward developing Medicare managed care plans focused on individuals with special needs—those who are institutionalized, have a severe or disabling chronic condition, or are dually eligible for Medicare and Medicaid.

Special Needs Plans serving dual eligibles must meet all the rules of Medicare Advantage plans except that they may limit enrollment to persons eligible for both Medicare and Medicaid. Members of a SNP may join or change plans at any point during the year, not just during the annual open enrollment.

In 2008, the Medicare Improvement for Patients and Providers Act added quality reporting requirements unique to SNPs. CMS worked with the National Committee for Quality Assurance (NCQA) to develop the additional reporting requirements for SNPs based on a set of six specially tailored Structure & Process measures and 15 HEDIS measures. The legislation also directed SNPs to develop a Model of Care that describes the plan's care management policy, procedures and systems. Over time, additional measures and a rigorous Model of Care approval process have been added to the quality reporting requirements for SNPs—in addition to the measures required of all MA plans. High performance on these additional measures is not recognized in the Stars quality ratings.

Dual Eligibles are Treated Differently Everywhere But in the Stars

Congress has repeatedly acknowledged the special needs of the dual eligible population: the Medicare Modernization Act of 2003 authorized health plans to create entities uniquely designed to serve dual eligibles and other populations with unique health needs. In 2008, the Medicare Improvement for Patients and Providers Act of 2008 acknowledged the need for specialized services from, and specialized oversight of, D-SNPs and other Special Needs Plans. The Act set additional standards for quality reporting, network adequacy, and contracting requirements.

The vulnerable nature and distinct health needs of dual eligibles is recognized implicitly in the lawmaking of Congress and regulations written by two Administrations. But no such acknowledgement exists with respect to rating and comparing D-SNPs. They are rated on the same scale as Medicare Advantage plans for quality incentive payments under the Stars rating system. Such a comparison tends to reflect the higher disease burden and social externalities borne by the population served by D-SNPs more than it would the care delivered by providers to this population, or the care management delivered by the plans themselves.

This apples-to-oranges comparison could have adverse consequences for the care of this population by providing plans an unintended incentive to select healthier populations. It could threaten the viability of D-SNPs: lower rankings, and the lower quality-based payments that would follow, result in fewer supplemental benefits for the population that is most in need and least capable of paying for those benefits. Traditionally, plans could apply 75 percent of the difference between the benchmark and bid to additional benefits and reduced cost-sharing for their enrollees, with the remainder returned to CMS. Under the ACA, the rebate is reduced to 70 percent for 4.5 and 5 star plans, 65 percent for 3.5 and 4 star plans, and 50 percent for plans that are rated 3 stars or lower.

About the Stars Quality Rating system

While Medicare Advantage plans have been compared on the basis of clinical quality and patient experience since 2006, it was the Affordable Care Act of 2010 that implemented a robust pay-for-quality system based upon these ratings. Once fully phased in, plans will earn quality bonus payments if they earn a rating of four or more stars. The quality bonus payments will effectively raise county benchmarks by up to five percent, and also scale rebate dollars available for extra benefits (or lower cost-sharing for enrollees) based upon a plan's Stars rating score. CMS implemented the payment portion through a demonstration which rewards 3-star as well as 4- and 5- star plans for the first three years.

The Stars rating system consists of quality measures drawn from the Healthcare Effectiveness and Data Information Set (HEDIS) developed by NCQA, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey developed by the Agency for Healthcare Research and Quality, the Medicare Health Outcomes Survey (HOS) and administrative data gathered by CMS. D-SNPs report on an additional set of measures, with no commensurate payment or recognition in the Stars rating system.

Dual Eligibles Have Fewer Financial and Health Resources

A review of the literature reveals the challenges inherent in caring for the dual eligible population: the Medicare Payment Advisory Commission (MedPAC) has collected data showing that 1 in 5 dual eligibles report being in poor health – more than twice the proportion of the non-dual-eligible population.[4] Dual eligibles have also repeatedly been shown to be less likely to receive preventive screenings, and result in lower quality scores, including HEDIS scores, compared to non-dual-eligible populations.

Dual eligibles tend to have fewer economic resources. More than half report incomes below the Federal Poverty Level (FPL), and more than 9 in 10 report incomes less than 200 percent of the FPL. Scarcity of income frequently serves as a barrier to access to care. Dual eligibles are also more likely to experience churning in their health coverage as a result of loss of Medicaid eligibility status which impacts continued enrollment in a D-SNP.

Mental illness is also more prevalent among dual eligibles than the Medicare population at large; according to MedPAC, they are more likely to suffer from cognitive impairment and mental disorders. Patients with mental illness are less likely to adhere to clinical guidelines or seek preventive screenings.

[4] Agency for Healthcare Research and Quality. *National Healthcare Disparities Report.* Publication #09-0002. www.ahrq.gov/qual/qrdr08.htm

Finally, dual eligibles tend to include more racial and ethnic minorities than the general Medicare population. One-third of dual eligible beneficiaries are African-American or Hispanic, and subject to the racial disparities that are persistent in health care. These disparities express themselves in fewer routine tests and preventive screenings, among other measures of care. For instance, in 2006 56.8 percent of non-Hispanic whites received a screening for colon cancer, compared with 48.6 percent of black patients and 37.3 percent of Hispanic patients. Other studies have found that areas with higher percentages of African-American patients had significantly lower HEDIS scores.

CMS agrees with this analysis. A report by the CMS Medicare-Medicaid Integration Office shows that the dual-eligible population includes higher proportions of women and minorities, are more than six times more likely to have incomes below the FPL, and three times more likely to have a disability than non-dually eligible Medicare beneficiaries.[5]

Disparities in care for minority populations are a pervasive issue throughout the entirety of the health care system. Plans, providers, policy leaders and others have made bridging these gaps in care a priority. Plans that serve large numbers of racial and ethnic minorities should be supported in their efforts to close disparities in care.

Pay-for-Quality Programs Must Recognize Underlying Disparities

While paying for quality is a laudable goal in its own right—and the concept behind the Stars Quality Rating system in particular is supported by ACAP and its member plans—a *Health Affairs* study posits that pay-for-quality programs can exacerbate racial and ethnic health disparities.[6] First, pay-for-quality programs may be designed in a manner that does not take the language or culture of a particular group of people into account. In addition, the article notes that low-income patients "might be less likely to adhere to treatment recommendations [and] might, for example, be less likely to obtain preventive care." Physicians may regard minority patients as less compliant and may avoid them in an effort to improve their outcomes on dimensions of a pay-for-quality system. This may lead to a vicious cycle in which physicians working in poor communities may be perversely incented to leave their communities in search of populations perceived more likely to be compliant.

The authors of the *Health Affairs* study suggested that physicians who work in poor minority areas be rewarded for improvement in addition to receiving incentives based on absolute quality scores. They also suggest that rewards be provided for reducing disparities in quality among minority groups.

This thought is reinforced by the opinions of health providers. A separate *Health Affairs* survey found that 3 in 4 physicians agreed that financial incentives should be given for high performance, provided that the measures used to construct the payment system were accurate. However, 85 percent thought that such measures currently in place do not sufficiently account for patients' medical condition or socioeconomic status.[7]

In addition, the metrics being measured and reported may not be appropriate to the health conditions of the members of D-SNPs, who have higher rates of multiple chronic conditions. Multiple studies

[5] Centers for Medicare & Medicaid Services. Medicare-Medicaid Coordination Office FY2011 Report to Congress.
[6] Casalino L.P., Elster A., Eisenberg A., Lewis E., Montgomery J., Ramos D. *Will Pay-For-Performance And Quality Reporting Affect Health Care Disparities?* Health Affairs, 26, no.3 (2007):w405-w414
[7] Casalino L.P., Alexander G.C., Jin L., Konetzka R.T. General internists' views on pay-for-performance and public reporting of quality scores: a national survey. *Health Affairs.* 26(2), 492-499. doi:10.1377/healthaff.26.2.492.

have suggested that strict adherence to clinical guidelines for patients with multiple comorbid diseases may diminish the quality of care delivered to such populations,[8] and increase the risk of adverse drug interactions or mortality.[9]

Stars Quality Ratings of D-SNPs Reflect Member Characteristics

A study by Ingenix Consulting of plan performance on measures of quality examined whether the performance ratings reflect member characteristics or actual differences in health plan performance. The authors regressed each of the 33 measures used in 2010 on 16 independent variables. The study was aimed at identifying characteristics that predict performance based on the underlying population.

Variables measured include:

- Percentage of D-SNP membership;
- Percentage of contract growth from January 2007 to December 2008;
- For-profit versus non-profit tax status;
- The age of the plan's Medicare Advantage contract as of December 2008;
- NCQA Accreditation status of the plan's Medicare line of business;
- Presence versus absence of commercial plan members;
- Market share of the contract in the Medicare Advantage markets;
- Percentage of African-American population in the plan service area;
- Percentage of Medicare Advantage penetration in the service area;
- Educational attainment of the population in the service area; and
- CMS regions, grouped into five categories.

Analysis was performed on the 352 Medicare Advantage contracts that reported a 2010 Summary Stars Score and reported enrollment in the CMS December 2008 Medicare Advantage Monthly Enrollment by contract file.

On average, the 28 Medicare Advantage contracts that included 100 percent D-SNP members had an average Stars rating of 3.11 in 2010, as opposed to the 167 contracts with no D-SNP membership, which reported an average star rating of 3.41. This is a statistically significant difference. In addition, the most common rating for purely D-SNP contracts was 2.5 stars, as opposed to the 3.5 stars most commonly reported by contracts with no D-SNP members[10] (Figure 1).

157 of 352 Medicare Advantage contracts – nearly 45 percent – include some SNP data in their quality reporting. This is because much of the SNP data is still embedded in the reporting for larger contracts. CMS has allowed SNP data to be obscured and reported with data from other Medicare Advantage plans offered by the same company. SNPs should be required to report distinctly from related Medicare Advantage benefit packages offered by the same sponsoring organization. There is no distinction made in the Stars system which distinguishes ratings for full-benefit versus partial-

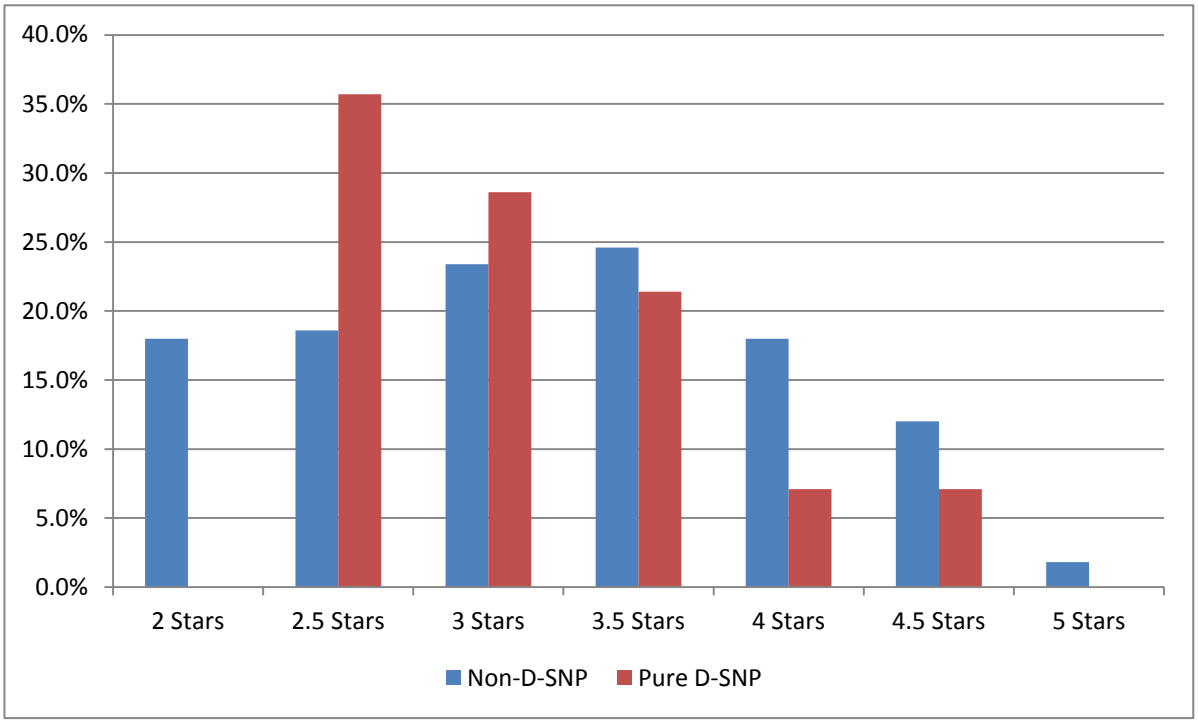
[8] Tinetti ME, Bogardus ST, Agostini JV. Potential pitfalls of disease-specific guidelines to patients with multiple conditions. NEJM. 2004;351:2870-2874.

[9] Boyd CM, Darer J, Boult C, Fried LP, Boult L, Wu AW. Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance. JAMA. 2005 Aug 10;294(6):716-24.

[10] Data for this analysis is from 2010. In 2012, 14 of 24 D-SNPs operated by ACAP plans received Star ratings of 3.0 stars or better. 8 of the remaining 10 did not have enough data to generate an overall rating.

benefit duals; such a distinction should be drawn because these populations may have very different characteristics.

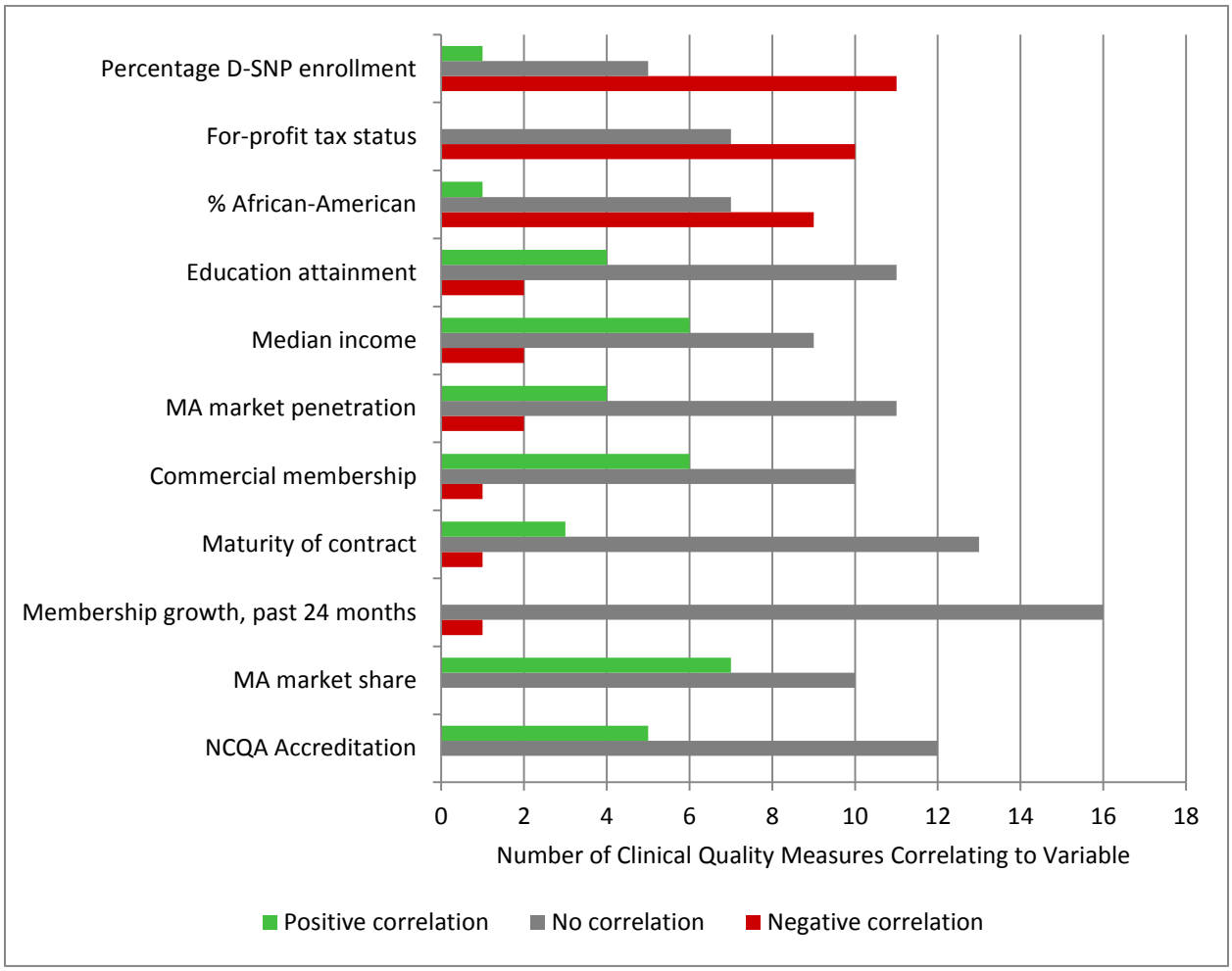
Figure 1. Distribution of Part C Stars Ratings: Pure D-SNP Contracts vs. non-D-SNP Contracts, 2010



While the non-D-SNP Medicare Advantage contracts show a fairly smooth distribution centered around 3 to 3.5 stars, the pure D-SNP plans are tilted heavily to the bottom of the scale, which strongly suggests that their lower performance is tied to systemic factors inherent in the characteristics of D-SNP plans.

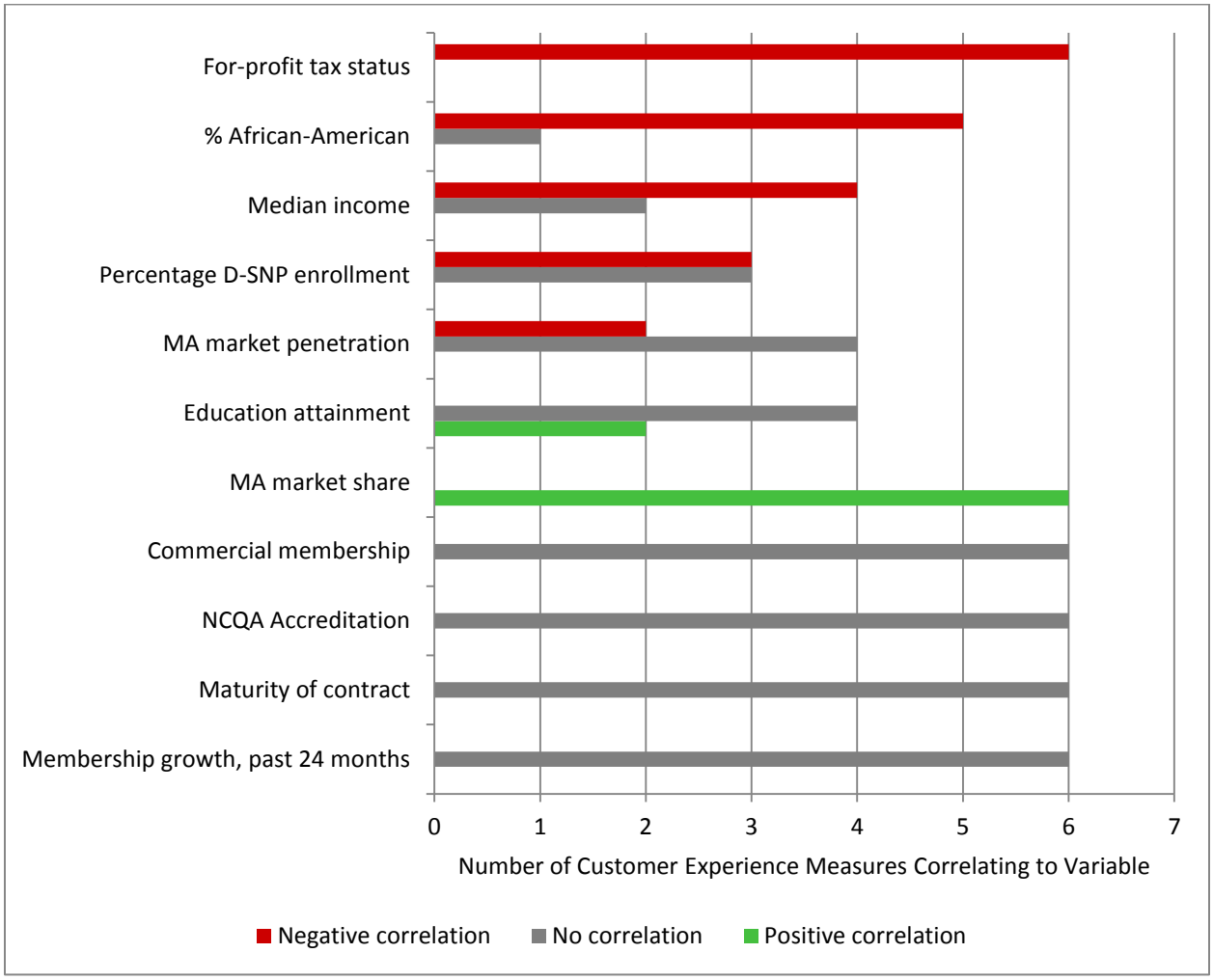
Ingenix regressed each of the 33 measures of care against the variables listed on the previous page; the results strongly suggest a correlation between lower scores on clinical quality and D-SNP enrollment. The results are summarized in Figure 2.

Figure 2. Summary of Regression Analysis of Variable Plan and Market Characteristic on Stars Quality Rating: Measures of Clinical Quality



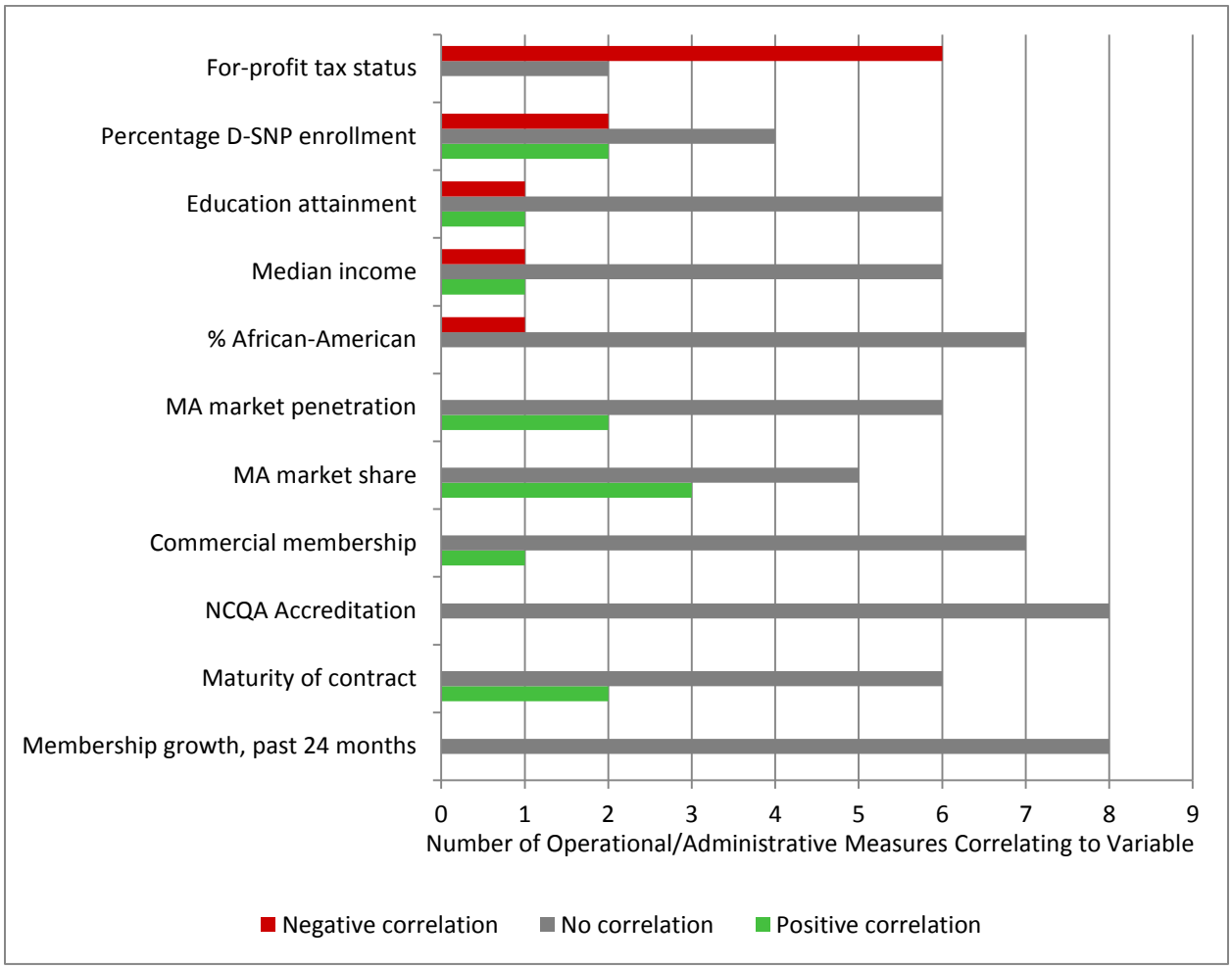
On dimensions of clinical quality, D-SNP enrollment has a significant negative correlation with 11 of 17 measures. It is not significant for five measures and positive for one. This strongly suggests that D-SNP enrollment is a strong predictor of lower performance on quality measures. Among the other variables analyzed by Ingenix, for-profit tax status was a strong predictor of lower performance, as was the proportion of African-Americans in a plan's service area.

Figure 3. Summary of Regression Analysis of Variable Plan and Market Characteristics on Stars Quality Rating: Measures of Customer Experience



Analysis of six measures of consumer experience paint a different picture: the driving plan variables here are for-profit tax status, which is strongly associated with lower performance on every dimension of consumer experience, and market share, which is associated with higher performance. D-SNP enrollment predicts lower performance on three measures and is unassociated with the other three.

Figure 4. Summary of Regression Analysis of Variable Plan and Market Characteristic on Stars Quality Rating: Operational & Administrative Measures



However, this correlation does not hold on measures of operation and administration: D-SNP enrollment is negatively correlated with only two of the eight measures, positively correlated with two and not correlated with four. Conversely, for-profit tax status was strongly associated with lower performance on measures of operation and administration.

This strongly suggests that contracts with significant levels of D-SNP enrollment are managed every bit as well — no better or no worse — than those with no such enrollment.

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.

Recommendations

Given the strong correlation between D-SNP membership and lower scores on clinical quality, a much weaker correlation with lower consumer satisfaction scores and no correlation at all to

operations and administrative ratings, one could reasonably conclude that the disparity in star rating between the typical D-SNP and the typical Medicare Advantage plan is not so much a recognition of the differences in care management between the two plans as it is a penalty for the composition of the D-SNP's population. If D-SNPs were performing as poorly on measures of operational management and consumer experience as they were on measures of clinical quality, one could reasonably conclude that the disparity in their Stars rating is a fair reflection of lower performance.

But the data show otherwise: D-SNP scores on operational and administrative measures show that D-SNPs are managed every bit as well as their Medicare Advantage counterparts. This suggests that the disparity in Stars ratings has more to do with the underlying health of plan population than the changes in operational improvement that pay-for-quality programs seek to foster. Accordingly, this could lead to an unintended incentive for plans to select members they perceive to be more likely to comply with care management directives.

The Path Forward

It bears repeating that ACAP supports the general aims of the Stars quality rating system, and the principles behind its use of incentives to reward high-quality care. Eight of ACAP's 22 D-SNP plans received 3.5 or more stars in 2011. ACAP believes that the Stars quality rating system rewards effective, efficient care which reduces underlying disparities and creates accountability while at the same time maintaining a fair payment system.

To better achieve these ends, ACAP recommends the following refinements to the Stars quality rating system:

Use appropriate measures for D-SNPs to better address the unique needs of dual eligibles. Dual eligibles are more likely to live with multiple co-morbid diseases, more likely to have behavioral and cognitive limitations and more likely to have limitations in activities of daily living. Others are looking for care that will support palliative and end-of-life needs. A draft set of appropriate measures for dual eligibles was released for comment by the National Quality Forum in April 2012. The work of this group should be considered as a more appropriate framework for the measurement of D-SNPs going forward.

Current measure sets should also be fine-tuned such that they are more appropriate for dual eligibles. For instance, some CAHPS and HOS survey metrics may result in lower scores for plans that serve members with cognitive impairments or advanced stages of illness — especially on questions which rely upon patient recall rather than clinical data.

There are other areas for concern in CAHPS, including an underlying downward case-mix adjustment to the raw satisfaction scores of all duals. This is problematic if a plan has 100% D-SNP enrollment and is being compared to a plan with only some duals. Further, it is quite possible that duals are enrolled in plans with better customer service and care management approaches that deserve the more positive response. CMS and AHRQ should look more closely at that case-mix adjustment. Further, CAHPS is available only in Spanish and English; D-SNP plans enroll a large number of duals who do not speak either language and are unable to complete the survey.

Use case-mix adjustment in calculating Stars performance ratings. Until refinements to the measures of clinical quality reflect plan activities instead of member demography, case-mix adjustment must be used so that Stars ratings can be used to discriminate among plans based on plan

management. This could be accomplished by simply separating D-SNPs from Medicare Advantage plans that serve the general population and comparing them to one another. Another approach would be a statistical risk-adjustment approach loosely based upon the risk adjustment system found in CAHPS scoring, or the CMS-HCC prospective risk adjustment system (although both systems have some flaws). This would remove the unintended incentive to seek gains in Stars ratings through member selection as opposed to quality improvement.

Compare quality of care delivered to duals in SNPs to that delivered in fee-for-service settings. Comparing the performance of D-SNPs to other Medicare Advantage plans which serve more affluent and healthy populations can be seen as a comparison of populations as much as a comparison of plans. Accordingly, it is important that policymakers' insight into the relative merits of integrated care settings provided by D-SNPs be buttressed by data. The best way to do so is to measure the quality of care delivered to dual eligibles in fee-for-service settings and compare it with the performance of Special Needs Plans serving similar populations.

Require reporting of quality data at the SNP benefit package level to allow for better comparisons among plans. The overwhelming majority of D-SNP plans – 157 of 185 contracts in 2010 – reported quality data that was embedded along with other Medicare Advantage plans offered by the same parent company. This makes comparison among the full spectrum of Special Needs Plans serving dual eligibles extraordinarily difficult. Requirements that mandate reporting of quality data at the benefit-package level would allow for greater visibility into plan performance and help beneficiaries and policymakers make more informed decisions.

Reward achievement in the Stars system in financial alignment demonstrations. The CMS Office of Medicare-Medicaid Integration announced that the Stars rating system will not be used in financial alignment demonstration programs. While room for significant improvement exists in the Stars system, baseline spending for D-SNPs that have earned 3 or more stars for the upcoming payment year may see their base payment *lowered* as part of these shared savings capitated alignment demonstrations. Such plans, which have earned bonuses despite the flaws in the Stars system, should not be unduly penalized for their participation in the demonstration programs.

Conclusion

The Stars quality rating system was founded with the right guiding principles in mind: plans which consistently perform at a higher level and deliver higher value should be rewarded. ACAP and its member Safety Net Health Plans support this goal. But in service of this worthy goal, there are several flaws in the system that may lead to adverse consequences, especially for vulnerable Medicare beneficiaries such as dual eligibles. Without changes to the way that D-SNPs are evaluated and compared against other plans, an unintended consequence of the rating system could be incenting plans to select healthier populations.

The good news is that many of these flaws are easily fixed. The Affordable Care Act provides the Secretary of Health and Human Services with a wide degree of latitude in defining a "quality plan" and implementing a rating system. Accordingly, many of the recommendations laid forth in this paper could be implemented through administrative action, allowing for flexibility in implementation, evaluation and refinement.

With the right measures and the right comparisons, the Stars quality rating system holds great promise for promoting and improving health care delivery and health plan administration.