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John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

December 9, 2015

Sean Cavanaugh
Deputy Administrator & Director
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

Cc: Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services

Submitted via: https://cmsgov.wufoo.com/forms/enhancements-to-the-star-ratings-for-2017/

Re: Request for Comments: Enhancements to the Star Ratings for 2017 and Beyond

Dear Mr. Cavanaugh:

The Association for Community Affiliated Plans (ACAP) appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) in response to the *Request for Comments: Enhancements to the Star Ratings for 2017 and Beyond.* ACAP intends for this letter to provide feedback to CMS on the proposed Star Ratings methodology for 2017 and beyond to ensure that plans are being evaluated for their performance, rather than the underlying health needs of their enrollee populations.

ACAP is an association of 61 not-for-profit, community-based Safety Net Health Plans located in 24 states. Our member plans provide coverage to over 15 million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare. Nineteen of our plans are Dual-Eligible Special Needs Plans (D-SNPs), fourteen of our plans are managed long-term care plans, and fifteen of our plans are Medicare-Medicaid Plans (MMPs) in the Financial Alignment Demonstration.

Impact of Socio-economic and Disability Status on Star Ratings

ACAP shares in CMS' belief that to achieve greater value and quality for all beneficiaries, the Star Rating system must not distort quality signals in measures or mask true differences in quality of care. The current methodology fails to adequately account for socioeconomic and disability status and ACAP is pleased that CMS is looking into ways to adjust for SES in the Star Ratings.

More information from CMS on both approaches is needed. ACAP is not able to determine how well the Categorical Adjustment Index or the Indirect Standardization adjust for SES with the information provided in the Request for Comments. We request that CMS provide more detail and numeric examples of how well each approach adjusts for SES, particularly for contracts with majority or 100 percent dual enrollment; estimates of how Star Ratings would change for contracts under each approach; and the strengths and weaknesses of each approach. We also ask for clarification on whether plans would have to have a minimum number of LIS/dual or disabled enrollees in order to receive an adjustment through either approach

For the categorical adjustment index, for instance, we also ask for clarification on whether institutionalized individuals would be one of the beneficiary subgroups included in the adjustment. ACAP also requests that CMS clarify whether the I-Factor will be applied before or after the Categorical Adjustment is applied.

For indirect standardization, we ask CMS to clarify which specific measures would be adjusted. CMS should also clarify to what extent, if at all, the subset of adjusted measures would change year-to-year. ACAP also requests that CMS clarify whether issuers should expect both upside and downside- adjustment with this approach: In a select few measures, plans with high proportions of disabled dual eligible beneficiaries outperform other plans – should these issuers anticipate a negative adjustment for these measures? We further ask for clarification as to how the adjustment under indirect standardization would interact with case-mix adjustment in the CAHPs survey.

ACAP urges CMS to provide more information on each of these models, including information on the accuracy with which each model adjusts for SES in contracts with large proportions of dual-eligible beneficiaries. Publishing specific examples and the strengths and weaknesses of each adjustment model will allow commenters to provide more useful feedback to CMS.

Other ACAP Comments

Removal of Measures from Star Ratings: ACAP strongly supports CMS' proposal to remove the High Risk Medication (HRM) measure from its Part D methodology. ACAP plans share many of the concerns that CMS highlighted with the measure, including unintended consequences of drugs appearing on the HRM list.

In addition, ACAP encourages CMS to also remove two additional measures: D2, Appeals Auto forward, and D10, Medication Plan Finder Accuracy from its methodology. CMS has stated that it will remove a measure if there is little to no room for improvement and a lack of variability in the scores. Measures D2 and D10 meet these criteria. According to CMS' 2016 Star Ratings fact sheet, the average D2 score is 4.5, the

highest of any Part C or Part D measure. Greater than three out of every four MA-PD contracts earned a 5-Star Rating for this measure (285/373). The D10 measure is defined in technical guidance as “A score comparing the prices members actually pay for their drugs to the drug prices the plan provided for this Website (Medicare’s Plan Finder Website). Higher scores are better because they mean the plan provided more accurate prices.” Though the average D10 score is not nearly as extreme as that of D2, the 2016 Technical Notes reveal a lack of variability across plans for this measure, diminishing its significance to consumers. The cut points that separate a 3-Star Rating form a 5-Star Rating are minimal: A 3-star plan scores between 97 and 99 on the adjusted accuracy index while a 5-star plan scores 100. 453 of the 478 (95 percent) contracts scored between 98 and 100 on the measure and 87 percent were rated 3 or 4 on the measure. **ACAP supports the removal of High Risk Medication measure and urges CMS to also retire the D2 and D10 measures.**

2017 CMS Display Measures: ACAP encourages CMS to leave certain measures that are new as display-only for several years, as their effectiveness and accuracy is tested and refined. In particular, ACAP suggests that the Part C measures, Hospitalization for Potentially Preventable Complications and Statin Therapy for Patients with Cardiovascular Disease be included only as a display measure for at least two years.

Forecasting to 2018 and Beyond: CMS was not specific in the exact changes the agency proposes to make in these areas. Instead, CMS listed broad issue areas it hopes to address in future years, including care coordination, depression and pain management. CMS should put specific measures and changes to the measures out for public comment before these measures become display measures or included in stars.

Changes to Existing Star Ratings and Display Measures and Potential Future Changes: CMS is considering updates to the Medicare Plan Finder Price Accuracy measure, including how current methodology is limited to 30-day claims filled at pharmacies reported by sponsors as retail only or retail and limited access only. If CMS pursues this, then the quality measure will differ from how pricing information is displayed on Medicare Plan Finder. As such, we request that CMS change plan finder submissions to allow plans to submit pricing data for 30 days.

For any changes CMS is considering making to display measures, CAHPs, and CMMI, ACAP requests that CMS identify the specific modifications to be made and give plans ample time to review the changes and prepare for them. For example, if the Medicare Plan Finder Price Accuracy measure were to be changed mid-2016, issuers would have insufficient time to account for those changes, and 2018 Star Ratings would be adversely impacted. If CMS is unable to give plans sufficient time to prepare, then CMS should hold off on making changes to measures for an additional year or more.

Conclusion

ACAP would like to reiterate its appreciation for the opportunity to respond to CMS' request for information on the Star Ratings methodology for 2017 and beyond.

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-eligible beneficiaries, is a consumer as well as a plan issue. Dual-eligible beneficiaries 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.

ACAP is prepared to assist the agency with additional information as needed. If you have any additional questions please do not hesitate to contact Christine Aguiar at (202) 204-7519 or Caguiar@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer