December 10, 2015

Sean Cavanaugh
Director, Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Comments 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 Alliance of Community Health Plans (ACHP) appreciates that CMS shares proposed methodology changes to the star ratings before the Call Letter is issued in February. We are pleased to submit the following comments in response to the Request for Comments issued on November 12, 2015. Please note that we also submitted these comments via the online form.

ACHP is a national leadership organization of community-based and regional health issuers and provider organizations. ACHP's member plans provide coverage and care for more than 18 million Americans. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems; most cover substantial numbers of Medicare Advantage (MA) enrollees. Eight of the 12 MA plans with a 5-star rating are offered by ACHP members. Our member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

A. Changes to Measures for 2017

6. Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR) measure (Part D)

ACHP recommends that CMS ensure consistency in the CMR measure by allowing plans to count towards their CMR rate the members who are enrolled through a plan's use of

expanded eligibility and who meet other plan-specific targeting criteria. The current calculation uses the cohort of MTM enrollees who meet the specified targeting criteria per CMS requirements. However, it is a matter of fairness to make sure that plans that choose to expand MTM eligibility to a larger population get credit for all of their members who complete a CMR.

We share CMS' preference to move towards the development and endorsement of outcomes-based MTM measures. We believe that outcomes such as decreased admissions, readmissions, and adverse drug events would better reflect the effectiveness of a MTM program.

B. Removal of Measures from Star Ratings

2. High Risk Medication (Part D)

ACHP supports the removal of the High Risk Medication (HRM) from the star ratings and its placement on the display page for 2017. We also agree with CMS that avoiding potentially inappropriate medications for beneficiaries is important for quality of care, and we encourage CMS to consider the HRM measure for the star ratings in the future upon making specification changes.

C. Data Integrity

ACHP has significant concerns with CMS' intention to review and apply any relevant MTM program audit findings that could demonstrate sponsors' MTM data were biased, outside of the Data Validation results. CMS had stated at its 2015 Medicare Advantage and Prescription Drug Plan Fall Conference that the new MTM audit program would be in a pilot stage for 2016 and findings would not apply to final audit results. The reasoning for this was to give plans an opportunity to provide feedback and for CMS to make needed adjustments to the MTM audit protocol as necessary. We believe it would be not be appropriate to apply MTM audit findings in the pilot stage to penalize plans, and we are concerned that plans could be penalized twice for certain measures – once if there are data issues under the program audit and again under the Data Validation results. We urge CMS to not apply the MTM program audit findings until the audit protocol is final.

ACHP recognizes the importance of accurate and reliable data for measures reported in the star ratings and CMS's ongoing efforts to identify new vulnerabilities where inaccurate data could exist. Given the potentially significant impact on star ratings of receiving a rating of "1," we request that CMS provide specific information on which data validation findings, under what circumstances, would result in reductions, and to which measures. We also recommend CMS establish a process through which plan sponsors can discuss with CMS, and potentially resolve, data problems.

D. Impact of Socioeconomic and Disability Status on Star Ratings

Many organizations, including ACHP, have asked CMS to address the challenges of Special Needs Plans and plans with high enrollment of dual-eligibles. We appreciate and support CMS' efforts to develop a response that is grounded in research. We urge CMS to take action that addresses these concerns starting with the 2017 plan year. While ACHP has been concerned about proposals that we think would undermine the integrity of the star ratings system, we recommend that CMS consider options such as:

- Review measures to make sure the denominator of each measure carefully reflects the recommended standard of care for the DSNP population.

- Evaluate the appropriateness of measures for the SNP population and potentially develop a limited number of SNP-specific measures (as CMS has done with the HEDIS Care for Older Adults and SNP Care Management measures). We caution that the relevance of clinical measures should be determined by clinical science and not by the type of plan in which a beneficiary is enrolled.

- Consider DSNPs with particularly challenging populations – for example, large numbers of enrollees who have complex health and social problems, perhaps involving behavioral health needs – as outliers so that they are excluded from reporting on certain measures that may not be applicable.

- Consider temporary payment of the quality incentive bonus for DSNPs at the 3.5 star level for 2017 and possibly 2018, allowing CMS time to consider other options and plans to continue their quality improvement efforts.

CMS has indicated their intent to work with measure stewards to update their technical specifications accordingly. We support this effort as the fairest, and most transparent, path to achieving appropriate measures across the Medicare Advantage population. Generally, we believe that CMS should consider policy options such as those we have previously suggested to address the concerns of SNP sponsors. ACHP believes these proposals are a better long-term approach than risk-adjusting quality measures for socioeconomic or disability status.

Measure risk adjustment is appropriate when there is a clear external factor that affects performance on a measure – for example, adjusting for age on mortality measures. But risk adjustment is not appropriate when it "risk adjusts away" problems of high quality care that the health plan and its delivery system partners are expected to deliver, regardless of the population. In that case, variations in outcomes by income, race or other factors included as adjustments to the measures are hidden, even though these variations may account for significant differences in the treatment of the patient across different plans or providers.

CMS has attempted to address these concerns in this RFI by focusing on "within-contract" differences. While we agree that this is a preferable approach to looking at difference across contracts, it still falls short of the "causation" threshold CMS established when it submitted its first request for plan data on this issue a year ago. For example, are lower scores in some

quality measures by those with low SES driven by population characteristics (like low medical literacy) or plan characteristics (like access to providers in low SES neighborhoods)? Both of these factors would drive within-contract differences, but only the former would represent a factor that we believe should be accounted for in a risk adjustment system. Because of issues such as these, we believe any quality measure risk adjustment proposal will be unable to fully create a fair performance evaluation system across MA plans. Nonetheless, as CMS considers two temporary proposals for risk-adjustment, we believe there are several issues that need to be considered if one of these proposals is implemented on a temporary basis.

Based on the information provided in the Request for Comments, the issues raised below, and the absence of data from simulating the results of these options, ACHP finds it very difficult to provide a fully-developed evaluation of the "Categorical Adjustment Index" and "Indirect Standardization" approaches. We offer the following concerns and questions that we hope CMS will address as it continues to consider these or other options.

Data Simulation: ACHP is concerned that neither proposal, as outlined in the Request for Comments, contains sufficient detail to fully evaluate its impact and sufficiency. We urge CMS to provide simulation results of both the "Categorical Adjustment Index" and "Indirect Standardization" approaches and create the opportunity for additional feedback from plans before a final decision on implementation is made. If CMS decides to include either of these options in the Call Letter in February, we believe that simulation data should be provided at that time so the plans can assess the impact of the adjustment.

Data Collection: As ACHP understands these proposals, each measure would be adjusted based on the proportion of individuals with LIS or disability status within its denominator (at least at the measure-level adjustments). This would require linking plans' HEDIS reporting systems with CMS data from plans on LIS and disability status. Because of the importance of capturing this information accurately for proper adjustment, we are concerned there will not be adequate time to properly review whether these assignments have been done accurately. We believe these concerns about the ability of plans to adequately review the proposed adjustments for 2017 are significant enough so that CMS should make participation optional for the 2017 star ratings until plans can review whether their data is being linked to HEDIS results accurately.

ACHP is also concerned with the use of LIS status as a proxy for low-SES. While income is a component of LIS qualification, the qualification for the LIS benefit has different processes inside and outside of dual-eligible plans. Because LIS status is deemed for dual-eligible plans, but requires an administrative process outside of a dual-eligible plan to qualify, we believe SES is over-estimated in non-dual-eligible plans by using LIS as a proxy for income.

Maintaining Transparency: ACHP has observed that when existing measures (such as the CAHPS results) undergo adjustment, detailed, unadjusted performance data is not made public. The public availability of detailed, unadjusted, performance data is essential to plan benchmarking and improvement activities. If CMS adopts either adjustment approach, we request that CMS continue to provide the detailed, unadjusted performance data by plan, the

detailed equations used to make any adjustments to performance, and detailed adjusted performance scores. Additionally, we encourage CMS to adopt total performance transparency for all current risk-adjusted measures.

Multiple Contract Organizations: One potential consequence of these proposals would be an unfair adjustment for organizations with multiple contracts in the same service area. For example, consider a plan that operates two contracts in a service area – one mostly consisting of non-LIS beneficiaries and one-tailored to a high-need, low-SES population in a DSNP plan. Furthermore, consider that this organization dedicates additional resources to its low-SES dominated contract, such that both contracts receive a final star rating of 3.80 stars (which rounds up to four stars). While the low-SES contract would likely receive a higher star rating under these proposals, the contract with fewer low income individuals would have its star rating reduced (possibly to the point of losing its quality incentive payments). Here, the organization has demonstrated that it provides superior quality to low-SES members, but happens to do so in a separate contract. However, because the adjustment models are based on national differences of within-contract performance, this organization's superior performance in treating low-SES members cannot be accounted for across contracts.[1] ACHP recommends that CMS make allowances in its proposed approaches to provide relief for organizations that may be unfairly treated as a result of national adjustment when within-organization performance demonstrates superior quality.

Cut-Point Issues: Both proposals seem to suggest that CMS will maintain cut-points based on unadjusted scores rather than determine new cut-points. ACHP is concerned that if CMS believes that risk-adjustment provides a truer measure of plan performance, then CMS should consider recalculating new cut-points for the adjusted measure distributions for star assignment determination if either proposal is implemented. To this end, ACHP would like CMS, as part of its simulation, to run both proposals with and without re-determined star rating cut-points for the individual measures.

Advanced Categorical Adjustment: CMS has requested feedback on whether plans would prefer an "advanced" Categorical Index Adjustment to star ratings to provide advance notice to plans. While this would provide some increased ability to review calculations, by the time this information is available to plans, it would be well after most care for the measures proposed to be adjusted is delivered; thus, the overall result is unlikely to be influenced. This approach could also create problems for contracts that start SNP plans, drop SNP plans, or have major changes in underlying demographics from one year to another. These shifts could have the potential to significantly decrease the accuracy of the Categorical Adjustment Index. Furthermore, the advanced option would also create issues for contracts that are in their first year of reporting HEDIS. These contracts could have a star rating, but would have no Categorical Adjustment because results were not available for the previous year.

Measure Inclusion: If CMS pursues either of these options, ACHP would recommend including only measures for which the adjustments would result in several point changes in

[1] This issue could also affect plans in the opposite direction where they receive positive adjustments even though performance in a higher SES contract is low.

score performance; if adjustments would generally result in changes of a point or less, there is little value gained from the additional complexity. We would also be concerned about including measures for which the 5-star performance threshold is close to 100% (*e.g.,* Adult BMI assessment, Kidney Disease Monitoring etc.). For these measures, a plan with 100% performance could be adjusted below a 5-star threshold, so that obtaining a 5-star rating on that measure becomes impossible.

CMS also proposes adjustment for several measures that are included as part of the HOS survey. Because of differences in timing and the survey-based nature of HOS, we are concerned that adjustment of HOS measures could not be implemented in a comparable way to adjustment of the HEDIS measures.

Comparison between Approaches: As noted above, ACHP does not believe there is sufficient information to provide a fully developed evaluation of the "Categorical Adjustment Index" and "Indirect Standardization" approaches. We believe that both options have strengths and weaknesses. Based on our conceptual evaluation, we have highlighted particular concerns with each approach that we hope will be addressed should either option be adopted.

We are concerned about how determinative the assignment of categories will be in the "Categorical Adjustment Index" approach. We believe that this will have a disproportionate and unfair impact on high-performing plans that will not only have downward adjustments that reflect measure score changes, but also the loss of r-factor and improvement measure points. Additionally, 4.5 and 5 star plans are likely to lose more r-factor points, on average, than 4 star plans, because higher mean plans are eligible to earn more r-factor points. If plans with near 4-star performance are categorized with 4.5 and 5 star plans, then they could lose r-factor points they were not eligible to obtain for their contract (because they would be averaged with plans who are losing r-factor points) – essentially getting over-penalized by being grouped inappropriately. Finally, categorical adjustment does not account for the fact that not all contracts report all measures. Plans that report a reduced number of measures could be given adjustments that are reflective of their category rather than the set of measures their contract reports.

The "Indirect Standardization" proposal seems to avoid the unfairness that could result from contracts being categorized in unrepresentative groups. However, it does create the possibility of more variable results for plans that have similar overall performance and similar LIS and disability proportions. This would happen because sometimes the individual measure adjustments will result in a star rating change, while sometimes the adjustment will keep a contract's score at the same star rating level. Thus, some plans will, by chance, cross several star rating cut-points, while others will cross few or none. In some cases, these cumulative cut-point changes will result in the loss (or gain) of an overall star rating level. Because of our earlier concerns that risk-adjustment models are insufficient to capture true causality of LIS and disability status effects on performance (creating a larger than justified downward adjustment for contracts with fewer LIS and disability members), ACHP recommends that if CMS moves ahead with either of these adjustments, they be implemented in a hold-harmless framework.

E. 2017 CMS Display Measures

2. Medication Reconciliation Post Discharge (Part C)

ACHP recognizes the benefits of this measure in promoting high quality care. However, we recommend it remain on the display page for an additional year beyond 2017 due to concerns regarding the validity of the measurement methodology. ACHP member plans have encountered difficulty in collecting accurate information that medications were reconciled post-discharge for their D-SNP population. Given this difficulty and the lack of experience in applying the measure for a larger population, an additional year on the display page would allow more time to address questions of methodology and appropriateness of the population for the measure.

4. Statin Therapy for Patients with Cardiovascular Disease (Part C)

ACHP is concerned that this measure does not account for statin intolerance among certain patients, which is an issue that has been examined in clinical studies. ACHP member plans have seen instances of patients with atherosclerotic cardiovascular disease who are deemed statin-intolerant after numerous trials with different statins and dosages. Given the occurrence of members who cannot tolerate statin therapy, ACHP urges CMS to examine ways to exclude members with a statin intolerance from the measure.

If this measure is added to the 2018 star ratings, ACHP is also concerned plans will have inadequate time to understand and implement effective clinical interventions through coordination with providers, since plans will only have access to relevant HEDIS data by the end of May 2016. Given this concern, ACHP recommends CMS consider keeping this measure on the display page for an additional year.

5. Asthma Measures (Part C)

ACHP would like to reiterate the reservations we conveyed in our comments from last year about the asthma measures that will be included in the 2017 display page, and we ask that CMS carefully consider these concerns. There appear to be drawbacks to the measures for the under-65 population that are likely to apply to Medicare patients as well – and, in any case, insufficient testing of the measures in the over-65 population. We offer the following brief comments and urge CMS to continue to consult with clinical experts:

- Asthma Medication Ratio: We understand that it is difficult to differentiate older patients with asthma from those with COPD, as both may exhibit a chronic obstruction. Applying the measure in the star ratings is likely to prompt expanded use of treatments that may not be appropriate for Medicare patients whose diagnosis is not straightforward.
- Medication Management for People with Asthma: We understand that the measure does not reflect NIH recommendations for step-down asthma controller therapy or management of patients who exhibit seasonal variations. There are also questions about the effect of the measure on clinical outcomes for under-65 patients that are likely to apply to Medicare patients as well.

Given questions about the clinical appropriateness and effectiveness of these asthma measures, and insufficient testing in the over-65 population, we recommend that this may not be the best avenue for assessing asthma care in the star ratings. Effective control of an enrollee's asthma in a way that allows the enrollee to function effectively and avoid having to go to the emergency department ER may be a preferable way to assess how well the health plan is taking care of asthma patients. We encourage CMS to continue to study the asthma issue and work with measure developers on approaches that better reflect how well the enrollee's asthma is controlled, rather than whether he or she is receiving certain medications.

Forecasting 2018 and Beyond
F. New Measures

2. Depression Measures (Part C)

ACHP supports efforts to appropriately recognize plans that effectively manage depression and reduce its symptoms, but we have concerns about the Depression Remission or Response in Adolescents and Adults (DRR) measure. We are concerned that the measure may over-emphasize the ability of plans to negotiate with providers the exchange of PHQ-9 data via electronic clinical systems, as opposed to accurately assessing the reduction of depression symptoms. As CMS continues to examine depression measures, CMS should consider approaches that measure reductions in MCS scores from the HOS for members with high baseline scores.

Thank you for your consideration of ACHP's comments. Please contact me at hshapiro@achp.org if we can answer any questions or provide additional information.

Sincerely,

Howard B. Shapiro
Director of Public Policy