August 18, 2010

Cynthia Tudor, Director
Medicare Drug Benefit and C&D Data Group
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Cynthia:

On behalf of the more than 200 members of DMAA: The Care Continuum Alliance, I want to thank you for the opportunity to share our views on the Medicare Advantage Health Plan Quality and Performance (Star Ratings).

DMAA: The Care Continuum Alliance represents organizations providing services along the continuum of care to more than 160 million Americans through wellness, chronic care management and complex case management. Our members include wellness, disease management and population health management (PHM) organizations; health plans; labor unions; employer organizations; pharmaceutical manufacturers; pharmacy benefit managers; health information technology innovators and device manufacturers; physician groups; hospitals and hospital systems; academicians; and others. These diverse organizations share DMAA: The Care Continuum Alliance's vision of aligning all stakeholders toward improving the health of populations. Our members seek to improve health care quality and contain health care costs by providing targeted interventions and services to individuals who are well, at-risk or managing one or more chronic conditions. Our members provide services important to achieving the existing Star Ratings measures and will likely serve a critical role in achieving future outcomes measures.

Through advocacy, research and promotion of best practices, DMAA: The Care Continuum Alliance advances population-based strategies to improve care quality and outcomes and reduce preventable costs for individuals with and at risk of chronic conditions. As discussed on our August 3rd call with you and your team, we share the goal of improving the quality of care for Medicare beneficiaries and support CMS' efforts to improve the Star Ratings. We appreciate the opportunity to provide input and comment as you move forward with revisions to the Star Ratings program and our specific comments are contained herein. In general, we support efforts to adjust existing measures and add appropriate new quality and outcomes measures. We encourage CMS to consider offering new measures as part of an optional set of measures and suggest the recent Phase I "meaningful use" core and optional measure sets as a model for structuring future Star Ratings measures.

**Policy Goal: Encouraging all plans to achieve higher quality**

Star Ratings were initially established and intended for consumer information and, as such, CMS' focus on differentiating between plans was appropriate for consumer education purposes. Evolving the Star Ratings to serve as a basis for quality bonus payments allows CMS the opportunity to incentivize health plans to achieve higher quality by focusing resources on care management programs. As such, DMAA: The Care Continuum Alliance recommends:

- *Re-weighting the existing measures to place higher value on quality/outcome measures and less weight on administrative/process measures*. While the latter are important, CMS should consider the relationship between incentives and where plans focus resources.

- *Comparing plans compared to a threshold*. We applaud CMS' indication from stakeholder meetings that they will move in this direction.

**Policy Goal: Moving to outcomes measures in the long run**

We fully support CMS' stated goal to move to outcomes measures from process measures. Program evaluation, through the use of performance measures, can reveal best practices in the delivery of care for beneficiaries. To that end, we suggest:

- *Care management outcome measures*. DMAA: The Care Continuum Alliance has developed a core set of measures for population health management, disease management and health and wellness programs. These highly validated measures, developed with NCQA and others, are updated and expanded annually.
    - Medical costs, health care utilization, health risks/behaviors, quality of life, health status, psychosocial drivers, program satisfaction and process/operations measures.
    - In addition, DMAA: The Care Continuum Alliance has developed quality measures of health status and participant satisfaction with population health management programs.

**Policy Goal: Moving care delivery towards a system that is patient-centered, efficient, effective, and high quality**

CMS can advance the goal of transforming health care delivery in Medicare Advantage through an evolved Star Ratings program. CMS can encourage plans to focus on improved outcomes and promote prevention, care management, care coordination, and patient engagement as the delivery system moves towards innovative models of patient care. Ultimately, the end result will be demonstrated in reduced hospitalizations, readmissions, etc. and high patient satisfaction. In the interim, DMAA: The Care Continuum Alliance believes CMS can include:

- *Chronic Care Improvement Programs (CCIP)*. CMS has indicated in various stakeholder meetings a willingness to consider and explore "transitional" mechanisms for achieving 4 star ratings during the Quality Bonus transition period. We support this concept and urge CMS to consider Medicare Advantage QIP/CCIP programs and Part D Medication Therapy Management (MTM) programs as an excellent place to identify leading care management practices that are producing positive outcomes for MA beneficiaries. In addition, the CCIP questionnaire could provide a rich set of data from which to pull.

**Policy Goal: Rewarding plans that improve the quality of care in their area**

Medicare Advantage plans, like managed care plans generally, are constrained by the localities in which they operate. As the Dartmouth Atlas and numerous studies document, health care delivery patterns in the United States vary by locality. Further, with respect to Medicare, articles by Jenks, et al, and others show that the quality of care in the national Medicare FFS program varies tremendously by locale. The federal government recognizes the great disparities in health care delivery across the country and has put programs in place to ameliorate the deepest chasms in health care quality: examples include the geographic payment modified in the Affordable Care Act (ACA), and programs to provide additional support to Health Professional Shortage Areas (HPSAs) and Medically-Underserved Areas.

Within these parameters Medicare Advantage plans, particularly those operating in areas of the country where providers struggle to provide excellent care, can and should be expected to "bend the curve upward" on healthcare outcomes for their members vs. a local mean. However, it is unreasonable to assume a health plan can, by itself, compensate for a geographic area's manifest disadvantages, including gross shortages of providers, lack of state of the art

equipment and training for those providers, geographic factors that discourage provider-member contact, and socio-cultural barriers.

Medicare is a national program, and the government's designation of excellence must be meaningful. And while our members work to reduce these disparities by engaging with beneficiaries and providers in improving the quality and efficacy of health care, we believe that plans should be encouraged to improve the delivery system in which they operate rather than penalized because of current variability that exists. This is not to say that CMS should award 4-stars to plans simply because they operate in certain areas; we suggest that CMS move towards a comparison between the MA plan and FFS health care outcomes. CMS has acknowledged in the user group call held for MA Contractors in June that it may be a good long term solution to this substantial measurement problem. CMS has also acknowledged that it may be useful to look at HPSAs or another federal designation to determine manifestly disadvantaged areas that might need to be considered apart from the national rating. We encourage CMS to pursue both of these paths as long term and near term solutions:

- *Comparison of plans vs. local/state FFS quality of care (depending on a plan's service area)*
    - Prevention measures as collected by QIOs and analyzed by CMS in the 2003 JAMA article "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001"
    - Readmissions rates as analyzed in the 2009 NEJM article "Re-hospitalizations Among Patients in the Medicare Fee-for-Service Program"
    - CAHPS FFS survey
- *Acknowledgement of the unique problems facing plans operating in profoundly rural or* HPSAs.

Thank you for the opportunity to provide input and comment. We are pleased to be a resource to you and look forward to working with you throughout this process.

Sincerely,

Tracey Moorhead
President and CEO

cc: Vicki Oates, Director, Division of Clinical and Operational Performance
Liz Goldstein, Director, Division of Consumer Assessment & Plan Performance
Marsha Davenport, Acting Director, Division of Medicare Advantage Operations