WELLPOINT

Improving Star Performance Measurement Methods and Ratings for High-Risk/High-Need Beneficiaries

SNP Leadership Forum

October 24, 2014

Agenda

Theme: Moving from Focus on Quality to Focus on Access

- Executive summary
- 2015 Scorecard Results: DSNP v CSNP
- DSNP Results: Analysis and Implications
- CMS RFI and Case Mix Adjustment

Executive Summary

Moving from Focus on Quality to Focus on Access

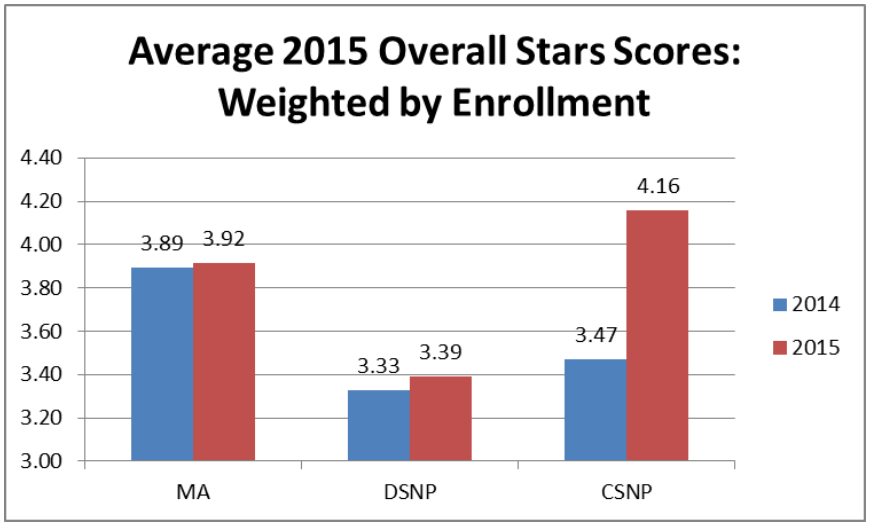
- CSNP performance beats MAPD industry in 2015
  - It is difficult to argue that the measurement system has bias
- DSNP performance continues to lag MAPD industry
  - Clinical measures perform lower, as expected
  - Every other domain performs lower, as well
  - Reweighting of quality improvement scores had perverse impact
  - DSNP members continue to face non-financial barriers to care that impact stars scores
- Conclusion
  - Case mix adjustment for clinical measures appropriate and necessary but not sufficient to level playing field
  - DSNPs must confront non-financial barriers to care in practice and in their evaluation of measurement system

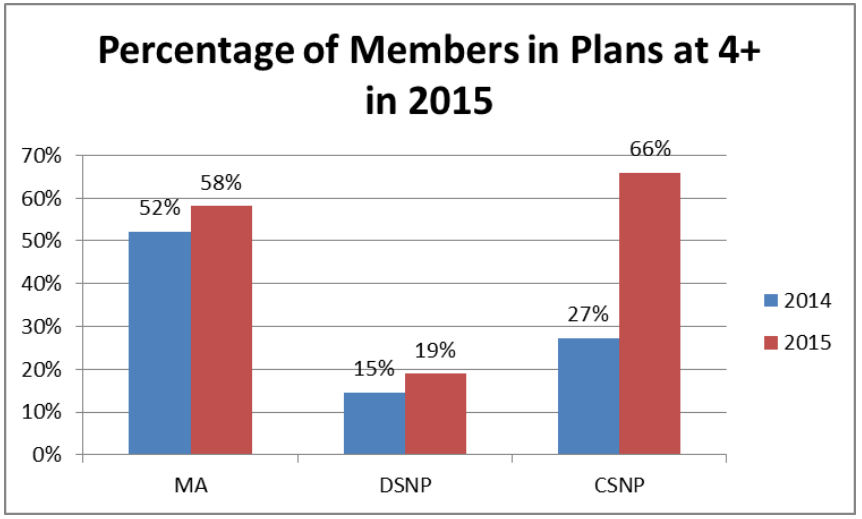
2015 Scorecard Results: DSNP v CSNP

High level 2015 scorecard results

DSNP and CSNP performance diverged in 2015

- DSNP contracts improved from 3.33 stars in 2014 to 3.39 stars in 2015
- The percentage of DSNP enrollees in 4+ star contracts increased from 15% in 2014 to 19% in 2015
- CSNP contracts improved from 3.47 stars in 2014 to 4.16 stars in 2015
- The percentage of CSNP enrollees in 4+ star contracts increased from 27% in 2014 to 66% in 2015
- ISNP population too small to assess in this analysis, see multivariate analysis



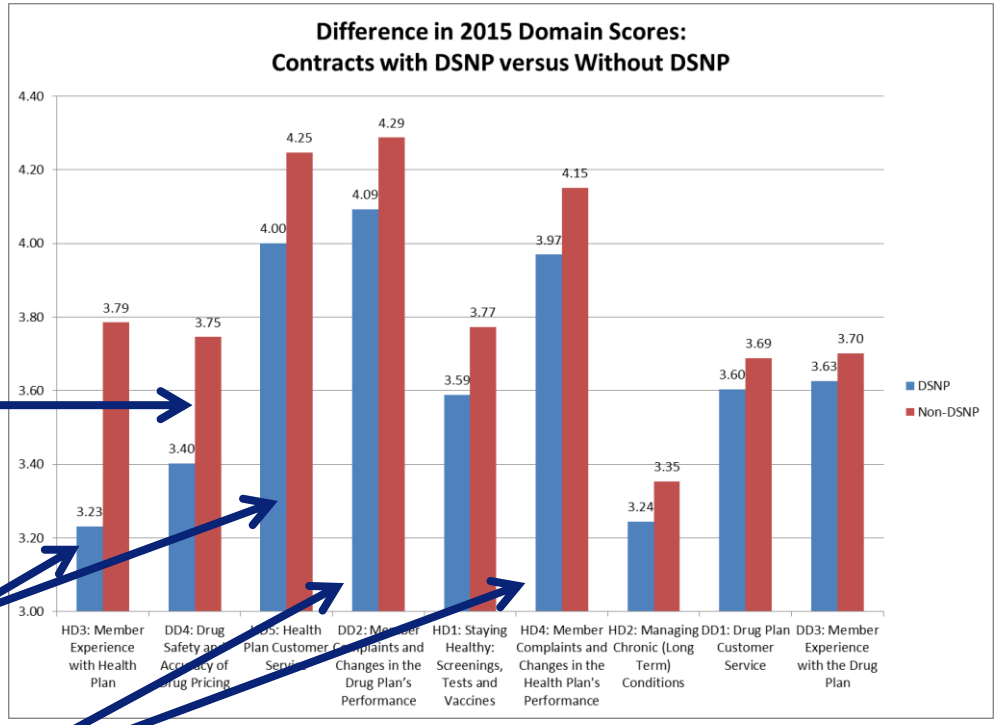


DSNP Scores: Analysis and Implications

2015 Scorecard Domain Scores: DSNP v MAPD

Contracts with DSNPS lagged MAPD contracts on all Domains

- Disparity in clinical performance was expected….
- … But, of 3 domains with largest disparities in DSNP/MAPD performance, ***just one is clinical***
- Non-financial barriers to care need attention, as evidenced by part C CAHPS and part C appeals performance
- Reweighting of quality improvement did not assist SNPs

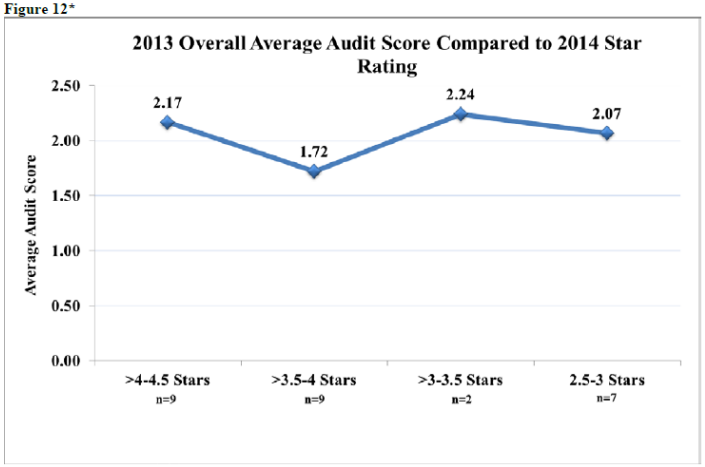


No evidence that lower stars scores is caused by poor plan administration

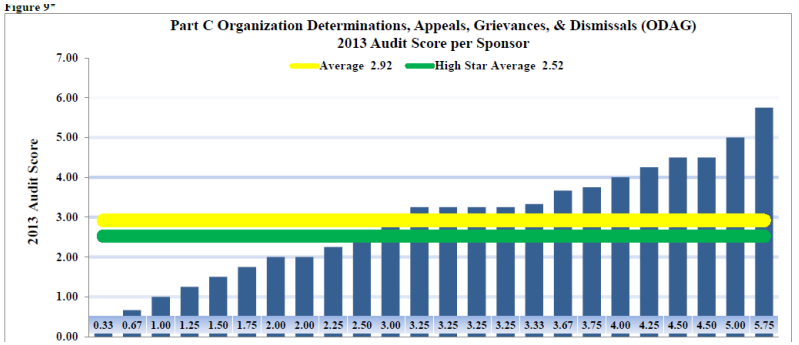
THE Hypothesis that good audit scores are associated with high stars performance is not supported….

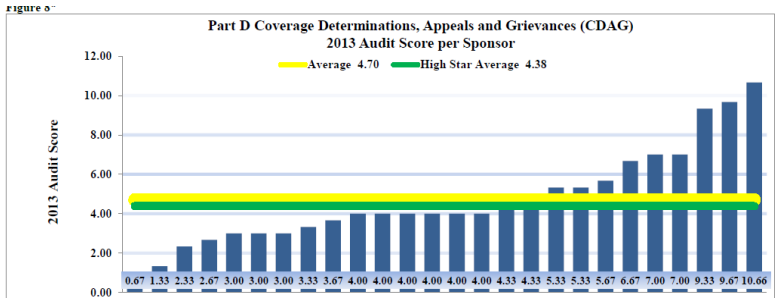
- There is no clear pattern that ODAG, CDAG and Formulary administration are associated with stars scores
- In other words, there is no evidence SNPs low scores for access are associated with poor administrative performance

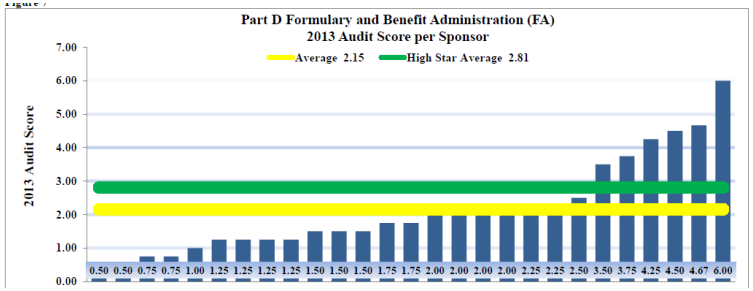
Figure 12*



*Audit and star rating scores were analyzed at the sponsor (parent organization) level. A lower audit score represents better audit performance. A higher star rating represents better quality and performance.





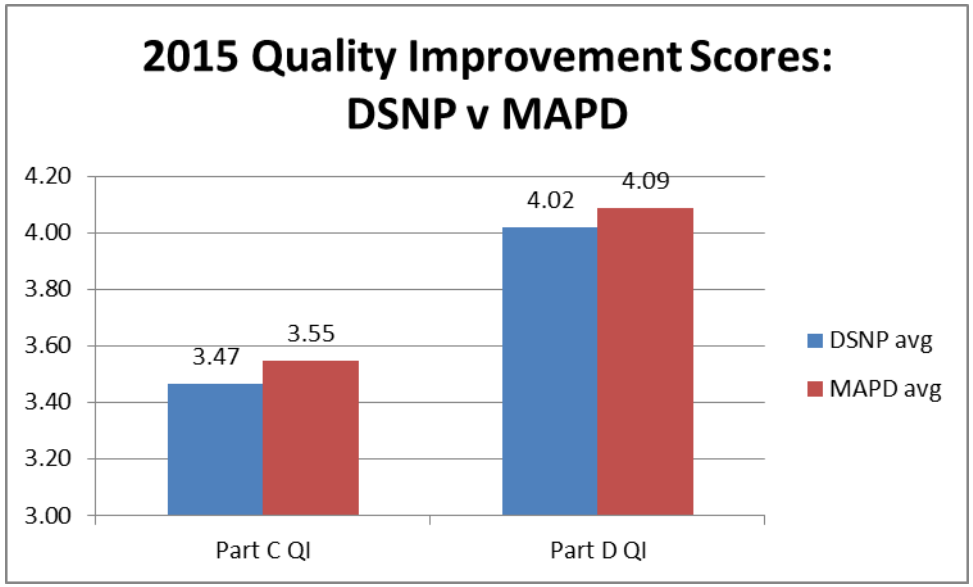


Lower is better

Source: 2013 Part C and Part D Program Annual Audit and Enforcement Report. October 16, 2014

Impact of Quality Improvement Score

- QI scores together contribute about 10% of total score
- DSNPs underperform MAPD
- If the DSNP population is harder to move than the MAPD population, then DSNPs will continue to lag on these measures:



From the Technical Specifications: "The improvement measure score is converted into a Star Rating using *the relative distribution method*."

Impact of Removing 4 Star Thresholds

Simulation data released by CMS in February of 2014 using 2014 Plan rating information indicates that it would have been harder for plans to achieve 4 Stars if existing 4 Star thresholds had been removed.

	2.0 Stars	2.5 Stars	3.0 Stars	3.5 Stars	4 or higher	Total
Original 2014 Ratings	1	16	109	143	162	431
Simulated Ratings	1	31	115	134	150	431
Difference	0	15	6	(9)	(12)	
% Change	0%	+94%	+5.5%	-6.3%	-7.4%	

Removal of predetermined thresholds, pushes plans down collectively. Simulation has fewer plans scoring 3.5 or higher and more plans receiving ratings of < 3.0.

Impact of removal of pre-determined 4 star threshold: Roughly 0.06 decrease.

	Original 2014 Thresholds	Simulated 2014 Thresholds	Impact
65th Percentile	3.686	3.622	(0.064)
85th Percentile	3.973	3.910	(0.063)

CMS RFI & Case Mix Adjustment

CMS Request for Information on Impact of Duals on Plan Performance

The Center for Medicare & Medicaid Services (CMS) seeks ***analyses and research that demonstrate that dual status causes lower MA and Part D quality measure scores.*** Alternatively, we are also interested in research that demonstrates that high quality performance in MA or Part D plans can be achieved in plans serving dual eligible beneficiaries and how that performance level is obtained.

Due November 3, 2014

Methodological Issues

- Sample size matters- effect sizes can be relatively small and small scale studies are underpowered
- Comparison of DSNP contract with non-DSNP PBP is incorrect as it masks true differences
  - Non-DSNP contracts contain meaningful dual populations, serving to narrow apparent differences
  - Duals enrolled in DSNP benefit from the enhanced model of care, serving to narrow differences
  - Recommended: compare duals and non-duals enrolled in non-DSNP plans
- Controlling for provider level effects is difficult
  - Small sample sizes predominate
  - Providers with multiple sights may have unobserved varying practice patterns

Univariate Analysis

- Of 13 measures studied, Duals performed worse on 9, better on 1
- Of 3 contracts where no difference was found, and for 1 contract where duals performed better, sample size was insufficiently powered

		Based on Admin HEDIS data							
		Dec, 2013 - Non Duals		Dec, 2013 - Duals			Statistical test		Alpha=5%, diff and sample size observed
		Comp rate	Denom	Comp rate	Denom	Diff	Z-val	P-val	Power
C01	Breast Cancer Screening	68.4%	75,272	57.1%	7,262	-11.3%	-19.0	<.0001	100%
C02	Colorectal Cancer Screening	47.3%	192,396	40.1%	15,787	-7.3%	-17.5	<.0001	100%
C04	Diabetes Care - Cholesterol Screening	84.5%	65,468	79.6%	9,302	-4.9%	-11.5	<.0001	100%
C14	Osteoporosis Mgt. in Women Who Had a Fracture	35.4%	5,057	34.7%	921	-0.7%	-0.4	0.7035	7%
C15	Diabetes Care - Eye Exam	51.3%	65,468	43.3%	9,302	-8.0%	-14.5	<.0001	100%
C16	Diabetes Care - Kidney Disease Monitoring	84.0%	65,468	85.0%	9,302	0.9%	2.5	0.0187	55%
C17	Diabetes Care - Blood Sugar Controlled (SCREENING ONLY)	87.9%	65,468	85.7%	9,302	-2.2%	-5.9	<.0001	100%
C20	Rheumatoid Arthritis Management	78.8%	5,062	73.9%	673	-5.0%	-10.4	0.0034	83%
		Based on internal Quick Win calculations							
		Dec, 2013 - Non Duals		Dec, 2013 - Duals			Statistical test		Alpha=5%, diff and sample size observed
		Comp rate	Denom	Comp rate	Denom	Diff	Z-val	P-val	Power
D11	High risk meds*	11.1%	408,135	17.8%	32,630	6.7%	36.5	<.0001	100%
D12	Diabetes Treatment	84.4%	67,897	82.7%	10,395	-1.7%	-4.5	<.0001	99%
D13	Adherence - Oral Diabetes	76.9%	61,240	76.3%	8,269	-0.6%	-1.2	0.221	23%
D14	Adherence - Hypertension	80.1%	178,732	77.8%	20,539	-2.3%	-7.9	<.0001	100%
D15	Adherence - Cholesterol	74.2%	178,071	74.8%	20,130	0.6%	1.8	0.074	45%

Example of Power Analysis

- Of 18 contracts assessed for A1c test, just 4 showed statistically significant differences
- When all 74,000 members in denominator were compared, the effect size of 2% was significant at p < .001

Why it matters:

- Most plans presenting data to CMS have relatively small sample sizes
- Results will vary, clouding the picture
- CMS may use variability to conclude no meaningful difference

Diabetes Care - A1C test (Screening only, not control)							
		Non-duals		Duals			
Contract		N	Rate	N	Rate	Diff	P-value
R5941	RPPO	23,632	86.62%	4,568	86.27%	-0.35%	0.53
H3655	OH HMO	9,925	89.57%	1,596	84.59%	-4.99%	0.00
H3370	NY HMO	8,555	83.85%	983	81.99%	-1.85%	0.14
H3342	NY LPPO	6,840	91.11%	459	89.54%	-1.57%	0.26
H8552	CA LPPO	4,782	87.85%	215	82.33%	-5.52%	0.02
H5529	OH LPPO	3,000	90.00%	206	85.92%	-4.08%	0.06
H1607	IN LPPO	1,830	90.00%	127	87.40%	-2.60%	0.35
H0564	CA HMO	1,173	89.77%	129	88.37%	-1.40%	0.62
H1849	KY HMO	832	89.06%	214	87.38%	-1.68%	0.49
H5530	KY LPPO	1,263	88.92%	175	91.43%	2.51%	0.32
H9947	GA LPPO	850	90.94%	121	82.64%	-8.30%	0.00
H1517	MO LPPO	774	88.76%	126	87.30%	-1.46%	0.63
H4909	VA LPPO	640	92.34%	29	86.21%	-6.14%	0.23
H2836	CT LPPO	314	91.72%	169	85.21%	-6.51%	0.03
H4036	WI LPPO	322	92.86%	44	90.91%	-1.95%	0.64
H6786	ME LPPO	250	97.20%	16	100.00%	2.80%	0.50
H5854	CT HMO	162	89.51%	103	81.55%	-7.95%	0.07
H9525	WI HMO	115	87.83%	21	95.24%	7.41%	0.32
	P-Value: consider significant if p< .05						

Multivariate Analysis: Logistic Regression including control variables

- Controls for demographics, health status, rural/urban residence
- Technique allows for precise calculations of unique impact of dual status after controlling for other factors
- Odds ratio allows for rough estimate of relate effect size

Measure number	Measure	Odds ratio	P(dual) at mean	P(non-dual) at mean	Delta
C01	Breast Cancer Screening	0.633	58.3%	68.8%	-10.5%
C02	Colorectal Cancer Screening	0.701	38.6%	47.3%	-8.7%
C03	Diabetes Care - Cholesterol Screening	0.838	83.1%	85.5%	-2.3%
C15	Diabetes Care – Eye Exam	0.821	45.9%	50.8%	-4.9%
C16	Diabetes Care - Kidney Disease Monitoring	1.132	87.2%	85.6%	1.5%
C17	Diabetes Care - Blood Sugar Screening (not control)	0.882	88.4%	89.6%	-1.2%
C20	Rheumatoid Arthritis Management	0.803	75.9%	79.7%	-3.8%
D11	High risk meds	1.295	12.4%	9.9%	2.5%

BCS Example

Odds Ratio Estimates

Effect	Point Estimate	95% Wald Confidence Limits	
Older than 64	0.634	0.598	0.672
AGE_FINAL (linear)	0.954	0.948	0.961
Employer Group Retiree	1.464	1.344	1.594
CMScontract_H3370 (NY HMO)	1.116	1.066	1.169
DUAL_ELIGIBLE	0.633	0.601	0.667
Institutionalized	0.156	0.103	0.235
Rural	0.814	0.771	0.858
Suburban	0.891	0.858	0.926
DxCG_COST_ABOVE5	0.913	0.907	0.92
DxCG_COST_BELOW5	1.248	1.233	1.263

- Odds ratio great than 1 implies the factor increases the odds of compliance, less than one implies reduced odds
- Statistically significant if confidence limits DO NOT bracket 0

Appendix: Control variable used in model

Member's age

Indicator if age<65

Gender

Contract (ex. OH HMO, OH LPPO, RPPO)

Charlson comorbidity index

DxCG Prospective Risk Score (as of Dec 2013)

Urban/Rural (RUC variable determined based on member's zip code)

Institutionalized (indicator from MMR)

Indicator EGR (member part of employee retiree group population)