CMS REQUEST FOR INFORMATION

Healthfirst appreciates the opportunity presented by CMS's September 9th Request for Information (RFI). Given the homogeneity of Healthfirst's membership, which is nearly entirely low-income, we were unable to conduct a meaningful regression analysis to explore the relationship of low income members and Star Rating performance within the same plan H-number[1]. However, we have attempted to document some of the qualitative challenges that low income Medicare members face that lead to noncompliance and, in turn, lead to lower Star Rating performance for the Medicare Advantage Prescription Drug (MAPD) plans that serve these members. We hope this information is helpful to CMS's goal of better understanding causality between low income or Dual status and lower Star Rating performance.

ABOUT HEALTHFIRST

Healthfirst is a one million-member, not-for-profit, provider-sponsored plan serving New York City and Nassau, Suffolk, and Westchester counties. Our model seeks to promote population health at the provider level by aligning financial incentives, utilizing financial risk transfer and other non-FFS methods of payment, and extensive partnerships with our network of providers. We are the largest Medicaid managed care plan in downstate New York with more than 850,000 members and earned the highest score on New York State's 2013 Medicaid managed care quality incentive program.

Through our MAPD plan (H3359), we serve about 120,000 MAPD plan members, more than half of whom are dually eligible for Medicare and Medicaid, and 80% of whom receive a Low Income Subsidy (LIS). After several years at the 3 and 3.5 star rating levels, we were very pleased to achieve 4 stars on the 2015 Star Ratings. We continue to be extremely concerned, however, that the Star Rating program does not sufficiently recognize the special challenges faced by low income members and the accomplishments of the health plans that serve them, and are very appreciative of CMS efforts in this regard.

HEALTHFIRST MEDICARE MEMBERS

Healthfirst Medicare members face a number of challenges related to socioeconomic and demographic factors. These challenges include low income levels, diverse cultural norms, and low health literacy. In addition, Healthfirst Medicare members also face challenges related to their clinical complexity.

More than half of Healthfirst Medicare members are dual-eligible and nearly 80% receive a LIS. **The 20% of members who do not qualify for a LIS (i.e., non-LIS members) are very similar to the members who do (i.e., LIS members); they live in the same communities and have a similar**

[1] We rigorously examined our data, but there was insufficient variability in Healthfirst Medicare member income for regression analyses to demonstrate the impact of income on Stars Rating performance.

demographic profile. The primary difference between the two groups is that non-LIS members earn slightly more than LIS members, exceeding the cut-off to qualify for a subsidy.

Healthfirst Medicare members are culturally diverse with a majority speaking a primary language other than English. This rate is more than double the national rate[2,i]. (Table 1) In terms of race, 46% of Healthfirst Medicare members self-identify as Hispanic, 36% as Black, and 9% as Asian or Other. Only 9% identify themselves as White, considerably less than the 77% of all Medicare beneficiaries who identify as White. (Table 2) The tremendous cultural diversity of Healthfirst members presents a challenge in providing care that requires members to adhere to evidence-based treatments which may differ from their cultural norms (e.g., Chinese diabetic who is advised to limit rice to better control blood sugar).

TABLE 1. Healthfirst Medicare Members by Language

Primary Language	Healthfirst Medicare Members			U.S. Population
	All Medicare	LIS Members	Non-LIS Members	
Primary Language Other Than English	53%	56%	40%	21%

TABLE 2. Healthfirst Medicare Members by Race

Race / Ethnicity[3]	Healthfirst Medicare Members[ii]	All Medicare Beneficiaries[iii]
White	9%	77%
Hispanic	46%	8%
Black	36%	10%
Asian or Other[4]	9%	5%

Education levels of Healthfirst Medicare members are low compared to Medicare members nationally. **70% of Healthfirst members, including 71% of LIS members and 51% of non-LIS members[iv], self-identify as having less than a high school education,** more than twice the rate of Healthfirst Medicaid members[v] and more than triple the rate of Medicare members nationally[5,vi]. This low level of education translates directly to lower health literacy which, in turn, contributes to poorer compliance to recommended screenings and treatments, resulting in poorer overall population health outcomes.[vii,viii]

In addition to the socioeconomic and demographic challenges outlined above, Healthfirst Medicare members are also more clinically complex than Medicare members nationally. For example, Healthfirst members are nearly twice as likely to screen positive for depression and are also nearly twice as likely to self-report a general health status of fair or poor. (Table 3) The clinical complexity –

[2] National rate of 20.8% includes people over 5 years old. Rate for people aged 60+ is even lower at only 14.6%.
[3] Persons of Hispanic origin may be of any race; all other racial/ethnic groups are non-Hispanic
[4] Includes Asian, Pacific Islander, American Indian, and Alaska Native
[5] 33.8% of Healthfirst Medicaid members and 23.2% of Medicare members nationally did not graduate high school.

especially the higher prevalence of depression – of Healthfirst members contributes to poor compliance with recommended medical treatment.[ix]

TABLE 3. Clinical Complexity of Medicare Members[x]

HOS Measure	Healthfirst	National
Positive Depression Screen	20%	11%
General Health: Fair or Poor	48%	26%
Pain Score of 5 – 10 (out of 10)	45%	28%
4+ Chronic Conditions	45%	38%

Beyond the challenges of income, language, health literacy, and clinical complexity, there is also difficulty in successfully contacting Healthfirst Medicare members. The telephone contact rate for Healthfirst Medicare members is 29% overall, less than half the rate of the general population[xi]. Somewhat surprisingly, non-LIS members are even harder to contact (26%) than LIS members (30%). (Table 4) This makes it more challenging to engage Medicare members in efforts to close gaps in care as well as to increase their health literacy and understanding of the actions needed to improve their health.

TABLE 4. Healthfirst Medicare Member Outreach

	Healthfirst Medicare Members			
Outreach Measure	All Medicare	LIS Members	Non-LIS Members	National
Telephone Contact Rate	29%	30%	26%	62%

HEALTHFIRST SERVICE AREAS

Neighborhoods

Healthfirst Medicare members are geographically concentrated in the highly urban New York City region, with 62% of Healthfirst members – including 65% of LIS members and 57% of non-LIS members – residing in 12 neighborhoods[6]. These 12 neighborhoods have an average poverty rate of 31%, more than double the NYC poverty rate of 15%. The high poverty rate in Healthfirst member neighborhoods is connected to higher crime rates[xii] and deep concerns about personal safety, which leads to restricted mobility and physical activity[xiii] and contributes to poorer health outcomes. These demographics constrain the solutions available to MA plans and their providers with respect to potentially successful interventions. For example, mail order pharmacy is not utilized due to member concerns about the security of the delivered package, even when that could increase convenience and adherence for certain members. In addition, member priorities around stable housing, physical security, and food security can easily trump priorities related to health maintenance.

[6] The 12 neighborhoods are: Washington Heights, High Bridge – Morrisania, Central Bronx, West Queens, Fordham – Bronx Park, Bedford Stuyvesant – Crown Heights, Hunts Point – Mott Haven, Southeast Bronx, Williamsburg – Bushwick, Lower East Side, East Flatbush, and East New York.

Health Professional Shortage Areas

66% of Healthfirst Medicare members reside in a primary care Health Professional Shortage Area[7] (HPSA). This includes 65% of Healthfirst LIS members and an even higher proportion of non-LIS members.

The proportion of Healthfirst Medicare members – whether they receive a LIS or not – residing in a HPSA is higher than the rate for Healthfirst Medicaid members, indicating that Healthfirst Medicare members are even more underserved than its Medicaid members and likely to experience access issues related to medical care. In contrast, only 24% of NYC residents and 18% of the population nationally reside in HPSAs. In the HPSAs where our Medicare members reside, the poverty rate is higher and the priority for practitioner placement is higher than for New York and for the entire United States. (Table 5) Residence in HPSAs is directly related to waiting times for appointments and related measures. This is a problem without an obvious solution; the providers within HPSAs tend to be hospital- or FQHC-based, in addition to local community physicians. They are more likely to be from the community, making them culturally and linguistically competent and preferred providers for the members. But they are also overwhelmed by the increasing volume of members and are only getting busier.

TABLE 5. Healthfirst and Primary Care HPSAs

HPSA Measure	Healthfirst Medicare			Healthfirst Medicaid[8]	NYC	U.S.
	All Medicare	LIS	Non-LIS			
% of population in HPSA	66%	65%	67%	63%	24%	18%
Avg. % poverty in HPSA	29%	28%	29%	20%	17%	18%
Avg. HPSA score[9]	15	15	15	15	12	10

MEASURES OF FOCUS

RHEUMATOID ARTHRITIS MANAGEMENT

Rheumatoid Arthritis Management measures the percentage of members with rheumatoid arthritis who filled at least one prescription for a disease modifying anti-rheumatic drug (DMARD). Healthfirst's performance was 75% in 2013, a steady improvement over the 2009 rate of 61%, but still only 3 stars. Healthfirst performance does not greatly differ between LIS and non-LIS members. (Table 6)

[7] Health Professional Shortage Areas (HPSAs) lack a sufficient number of health care providers to meet the health care needs of the area or population. They identify areas of greater need throughout the United States

[8] Includes Medicaid, Family Health Plus, and Child Health Plus membership. Medicaid is nearly 90% of the total.

[9] HPSA score rated on a scale from 1 to 25, where 25 is highest priority for practitioner placement

TABLE 6. Healthfirst Rheumatoid Arthritis Management Performance: 2013

	Healthfirst Medicare Members		
	All Medicare	LIS Members	Non-LIS Members
Distribution	100%	83%	17%
Rate	75%	75%	74%

The lack of a performance difference is attributable to the similarity of Healthfirst LIS and non-LIS members on the factors, described below, that drive noncompliance.

Healthfirst conducted a barrier study to understand members' reasons for not filling their DMARD prescription and identified several causes for noncompliance across LIS and non-LIS members. Each is detailed below with an actual member scenario.

(1) Transportation / mobility challenges: Aldo[10], a 68 year-old male in Queens, walks with a cane and is unable to stand or walk for very long. He has trouble getting to the pharmacy, which is several blocks away.

(2) Other Priorities: Billie, a 72 year-old female in East Harlem diagnosed with rheumatoid arthritis over 10 years ago, cares for 2 foster children and does not have the time to deal with the medication and its side effects.

(3) Medication Burden: Lydia, a 77 year-old female in Queens, is on several medications for hypertension and does not want to add more.

Because of the often severe side effects of DMARDs, members frequently do not want to take them. One Healthfirst physician commented that, in some cases, cultural distrust of physicians is amplified by the severe side effects and slow-acting nature of DMARDs ("My arthritis doctor doesn't care about me", "It won't make me better anyway"). In fact, some members believe that "prayer is safer and better than these horrible medications."

MEDICATION ADHERENCE

Medication Adherence measures the percent of members who adhere to their prescribed drug therapy across specified classes of medications. Healthfirst's performance on the three medication adherence measures in the Star Ratings has steadily improved since 2010 - by 6 points on diabetes and more than 9 points on RAS Antagonists and Statins. However, the average Star rating remains low at 2.3 stars.

A comparison of adherence rates between LIS members and non-LIS members in MAPD plans nationally shows that non-LIS members are more adherent across all three measures by 2 to 5 points. Healthfirst's experience is the opposite: Healthfirst non-LIS members are *less adherent* than

[10] All member names and other identifying information have been changed.

LIS members across all three measures by 5 to 7 points. (Table 7) This inverse pattern is evidence that Healthfirst non-LIS members are unlike most MAPD non-LIS members.

Table 7. Medication Adherence Performance: 2013

Measure	MAPDs		Healthfirst	
	LIS	Non-LIS	LIS	Non-LIS
Oral Diabetes Medications	75%	**77%**	**75%**	68%
RAS Antagonists	75%	**80%**	**74%**	69%
Statins	71%	**75%**	**67%**	60%

Note: Shaded cells denote the cohort of LIS or non-LIS members that had better adherence rates.

Healthfirst conducted adherence barrier surveys to support quality improvement efforts, and cost emerged as a top reason for non-adherence. Members routinely speak about pill splitting to off-set costs and making decisions about which of their many prescriptions to fill each month. Looking through the lens of a Healthfirst non-LIS member, who likely barely exceeded the cut-off to qualify for a subsidy, this deep concern about cost puts the situation into sharp focus: **Healthfirst non-LIS members earn too much to qualify for a low income subsidy, but do not earn enough to comfortably pay the co-pays for all of their medications**.

Healthfirst is transitioning to a formulary in 2015 with zero dollar copay generic adherence medications. While this will help Healthfirst non-LIS members to achieve adherence similar to Healthfirst LIS members, we expect that Healthfirst will continue to lag the MAPD average due to the impact of socioeconomic factors like race, education, and income. The relationship between medication adherence and socioeconomic factors has been demonstrated in multiple studies,[xiv,xv] including one which identified that more than a third of the variation in Medicare Star Rating adherence scores is tied to socioeconomic characteristics of members.[xvi]

Other serious barriers to adherence are transportation and safety challenges. Mary, a 78 year-old woman in Brooklyn, disclosed that the long walk to the pharmacy prevents her from always picking up her medications on time. Delivery service is not an option for her because she lives alone and does not feel safe with men coming to her home.

Dr. Isaac Dapkins, Director of the Division of Ambulatory Care at Bronx-Lebanon Hospital Center in the South Bronx, notes that unstable housing (e.g., no designated place to keep medications or have them delivered), cultural beliefs (e.g., fatalistic belief that medicine will not help, reliance on traditional remedies), and low health literacy (e.g., limited understanding of medication measurement concepts like milliliters) all contribute to medication non-adherence.

DIABETES CARE: BLOOD SUGAR CONTROLLED

Diabetic Care: Blood Sugar Controlled evaluates the percent of diabetic members who had an A1C test during the year that showed that the members' average blood sugar level was in control (<9%). Healthfirst's performance on this measure has steadily improved from 61% in 2009 to 72% in 2013. Despite this considerable improvement, Healthfirst's Star rating on this measure remains at 3 stars. Healthfirst performance rates are meaningfully[11] different for members who receive a LIS and those who do not. (Table 8)

TABLE 8. Diabetes Care Blood Sugar Controlled Performance: 2013

	Healthfirst Medicare Members		
	All Medicare	LIS Members	Non-LIS Members
Distribution	100%	79%	21%
Rate	75%	71%	78%

Poorer blood sugar control for LIS members seems to be at odds with their higher oral diabetic medication adherence rates. However, this discrepancy can be explained by the importance of diet and exercise on blood sugar control, and the great influence that cultural norms and health literacy has on diet and exercise. While Healthfirst Medicare members as a whole are culturally diverse and have low education levels, these factors are even more pronounced for Healthfirst LIS members[12], contributing to their poorer blood sugar control.

Cultural norms: Cultural beliefs and habits help to explain the continued challenge Healthfirst has faced in improving diabetic blood sugar control to a 4- or 5-star level. Dr. Miriam Vincent, Medical Director of Ambulatory Care at the University Hospital of Brooklyn, sees diabetic patients make poor dietary choices due to the cultural perception that "fat is healthy." Dr. Richard Ng, an internal medicine physician in Chinatown, observes that habits are difficult to change and many Chinese patients will not limit their rice intake.

Health Literacy: The low level of health literacy among Healthfirst's Medicare membership also contributes to poor blood sugar control. Inadequate health literacy is associated with worse glycemic control and may contribute to the disproportionate burden of diabetes-related problems among disadvantaged populations.[xvii]

Safety: Safety concerns are yet another reason that Healthfirst diabetic members struggle to control their blood sugar levels. Dr. Dapkins notes that older patients are often afraid to be outside due to high crime levels in their neighborhood. This leads to limited opportunity for exercise and limited access to healthy foods. In addition, patients with unstable housing have difficulty finding a safe place to keep insulin and testing supplies.

[11] Due to the small sample size of this measure, statistical significance tests have insufficient statistical power.

[12] 56% of Healthfirst LIS members compared to 40% of non-LIS members haves a primary language other than English.71% of Healthfirst LIS members compared to 51% on non-LIS members have less than a high school education.

PLAN ALL-CAUSE READMISSION (PCR)

Plan All-Cause Readmission (PCR) measures the percent of senior members discharged from a hospital stay who were readmitted within 30 days. Healthfirst performance has improved significantly for each of the last 3 years, from 17% in 2010 to 13% in 2013. (Table 9) Despite this improvement, Healthfirst's star rating is currently only 2 stars.

TABLE 9. Unadjusted[13] Plan All-Cause Readmission Performance: 2013

	Healthfirst Medicare Members		
	All Medicare	LIS Members	Non-LIS Members
Distribution	100%	81%	19%
Unadjusted Rate	14%	14.6%	11.8%

While PCR is adjusted for age, gender, and clinical factors, it is not adjusted for socioeconomic factors. Hu, Gonsahn, and Nerenz studied the impact of socioeconomic factors on 30-day readmissions and concluded that patients living in high poverty neighborhoods were 24% more likely to be readmitted.[xviii] They also found that married patients were less likely to be admitted, suggesting that the lack social support at home is a risk factor. This is consistent with the experience of Dr. Vincent, who notes that the lack of social support at home and the lack of reliable transportation lead to readmissions.

The case study included in this report illustrates some challenges related to socioeconomic factors that have contributed to readmissions for one Healthfirst dual-eligible member.

[13] This table shows unadjusted PCR values. PCR rates used in the Star Ratings include risk adjustment for age, gender, and clinical variables.

CASE STUDY: READMISSIONS

Member Profile: Female dual-eligible SNP beneficiary in her late sixties who lives alone in a low-income area of New York City

Medical Profile

- Main diagnoses include: Coronary Artery Disease (CAD), hypertension, depression, smoking, congestive heart failure (CHF), and aortic stenosis (recent diagnosis in July 2014)
- Home health aide assists with going to the store and to medical appointments.
- 13 prescription medications
- 5 inpatient visits so far in 2014, with 4 occurring within a 2 month period for CHF related to shortness of breath

Key Risk Factors for Readmission

- Lack of social support: member lives alone
- Clinical complexity: 4+ chronic conditions including depression and 10+ medications
- Unsafe neighborhood with high poverty rate: violent crime rate 2.5x NYC overall with murder rate 5x NYC overall; poverty rate is 31%, twice the overall NYC rate
- Low health literacy

Goal: Management of complex member with multiple health and socioeconomic challenges, including counter-indicated personal behaviors, in order to reduce reliance on hospital emergency departments

Care Management Support

- On-site Healthfirst Care Manager initiated care management during hospitalization and continued to meet in-person and on the phone 7 more times. Care Manager activities included:
  - Facilitated order and delivery of DME (blood pressure cuff and folding walker) and educated member on use
  - Scheduled PCP appointment and new cardiologist appointment
  - Met the patient for the cardiologist appointment
- Telephonic nurse case management is ongoing

Current Status

- Smokes despite repeated education efforts by PCP
- Received blood pressure cuff and has been taking BP daily. Reported normal findings
- Follow-up with PCP due in 2 weeks

OSTEOPOROSIS MANAGEMENT

Osteoporosis Management measures the percent of female members aged 67 and older who suffered a fracture and, within the next six months, had either a bone density test or filled a

prescription for a drug to treat or prevent osteoporosis. Healthfirst's performance on this measure was only 26% in 2013, with LIS member compliance at 25% compared to non-LIS compliance of 29%. (Table 10)

TABLE 10. Healthfirst Osteoporosis Management Performance: 2013

	Healthfirst Medicare Members		
	All Medicare	LIS Members	Non-LIS Members
Distribution	100%	81%	19%
Rate	26%	25%	29%

A number of factors contribute to Healthfirst's lower-than-desired performance rates. Dr. Vincent observes that both culture ("Black women naturally have strong bones") and health literacy ("Any radiation is dangerous") play a role in non-compliance, despite education efforts. She also notes that many patients simply forget.

To counteract forgetfulness, Healthfirst mailed letters to eligible members to inform them of their need for a bone mineral density test. Members' PCPs also received a copy of the letter. This letter was followed up by a phone call to help the member make an appointment.

Performance tracking in 2013, however, showed that this traditional letter and phone-based approach was not effective for Healthfirst members. This is consistent with Healthfirst's analysis of telephone contact rates which showed that only 29% of members were successfully contacted by phone, much lower than the general population, which has a reach rate of more than 60%.

In response to the lack of success with more traditional interventions, Healthfirst began offering in-home bone density tests to eligible members about a year ago. Through this intensive intervention, Healthfirst has greatly improved performance. Current performance through September 2014 is 44%, far surpassing the prior year rate of 26%. Remarkably, LIS member compliance improved to 45%, nearly twice the 2013 rate and exceeding the non-LIS rate of 36%. (Table 11)

TABLE 11. Healthfirst Osteoporosis Management Performance: Jan – Sep 2014

	Healthfirst Medicare Members		
	All Medicare	LIS Members	Non-LIS Members
Distribution	100%	81%	19%
Rate	44%	45%	36%

In-home bone density tests have proven to be an effective way to improve member compliance for hard-to-reach populations, and the success we have had supports the hypothesis that our members require more intensive levels of assistance. However, even with our significant improvement in performance, we expect to earn only 3 stars, which suggests that even the most intense and effective interventions will still not close the performance gap for low income members.

SNP CARE MANAGEMENT

The SNP Care Management measure evaluates SNPs (Special Needs Plans) based on the percent of members whose plan did an assessment of their health needs and risks in the past year. Healthfirst's performance on this measure varies greatly depending on the type of SNP that is reporting. The rate for Healthfirst D-SNPs was only 52%, while the Fully Integrated Dual Eligible (FIDE) product earned 83% and the I-SNP earned 97%. (Table 12)

TABLE 12. Healthfirst SNP Care Management Performance

D-SNP	FIDE	I-SNP
52%	83%	97%

Based on the rates by plan within Healthfirst's overall contract, it is clear that performance is related to the plan type. Plans like Healthfirst's I-SNP that focus on institutionalized members perform the best. This performance is a reflection of the captive nature of the member – there are no challenges with reaching the member when the member is in an institutional setting. Plans like Healthfirst's FIDE that focus on members requiring home care also perform well on this measure for similar reasons of physical co-location with the member.

In contrast, traditional dual-eligible plans perform much worse on this measure, in our experience, due to challenges with reaching the member as well as challenges in competing for their time and attention in completing the Health Risk Assessment (HRA).

CAHPS MEASURES OF NETWORK ACCESS

There are two CAHPS measures related to network access: (1) Getting Needed Care and (2) Getting Appointments and Care Quickly. These measures are case-mix adjusted for a range of factors, including dual-eligible status and LIS. However, they are not adjusted for important factors like the health care capacity in the region.

In the context of the CAHPS measures of network access, provider capacity is an important element. Medicare members who reside in HPSAs understandably rate measures of network access lower than members who do not reside in a HPSA. The intent of the CAHPS measures – to evaluate member perception of access to care – is valuable, but issues of health care capacity and infrastructure will convolute the measurement so long as the measures remain unadjusted for HPSAs.

CONCLUSION

Healthfirst has deep experience serving low income Medicare members, including both those who receive a low income subsidy as well as those who do not. Based on our experience and the experience of our network physicians, we have identified several challenges that low income

Medicare members face that lead to non-compliance and ultimately result in lower Star Rating performance for the Medicare Advantage plans that serve these members.

Across 10 Star measures that collectively determine more than a quarter of a MAPD's 2015 Star Rating, we identified four factors that contribute to lower performance rates among low income members. These include: cultural norms, low health literacy, lack of safety and transportation, and other life challenges[14]. (Table 13)

TABLE 13. Factors Leading to Lower Performance Among Low Income Members

		Factors Leading to Non-Compliance			
Measure(s)	% of 2015 Stars	Cultural Norms	Health Literacy	Safety / Transportation	Other Life Challenges
Rheumatoid Arthritis Treatment	1%	X	X	X	X
Medication Adherence	11%	X	X	X	
Diabetes Care: Blood Sugar	4%	X	X	X	
Plan All-Cause Readmission	4%		X	X	X
Osteoporosis Management	1%	X	X	X	
SNP Care Management	1%				X
CAHPS Network Access Measures	4%			X	
Total	**26%**				

We appreciate CMS's willingness to investigate the causes of poorer Star Rating performance for plans serving low income beneficiaries and the opportunity presented by the September 9th RFI. For questions about this submission or any supporting detail, please contact Joyce Chan, Assistant Vice President of Clinical Performance, at 212-801-6029 or jchan@healthfirst.org.

[14] "Other Life Challenges" includes circumstances that make measure compliance a lower priority. For example: the member who fosters 2 children and does not have the time to take a DMARD for her Rheumatoid Arthritis.

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