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To: ***Submitted via email to:*** *PartCandDStarRatings@cms.gov*.

From: ***Minnesota Department of Human Services, CMS Federal State Partnership to Align Administrative Functions for Improvements in Beneficiary Experience***
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Re: **Comments:** ***Request for Information Regarding Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees***

A. INTRODUCTION

1. MN Integrated FIDE-SNPs

The State of Minnesota Department of Human Services (MN DHS) contracts with eight Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) to provide integrated Medicare and Medicaid service about 35,500 full benefit dually eligible (FBDE) Medicaid seniors age 65 and older under the Minnesota Senior Health Options (MSHO) program. DHS shares an interest with CMS and MSHO plans in assuring that Medicare quality measures, Star ratings and bonus payments are appropriate and fair for programs serving a disproportionate share of older, frail and dually eligible seniors. We appreciate this opportunity to respond to the recent RFI asking for information on differences in MA and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual Eligible Enrollees.

MSHO includes all Medicare and Medicaid services including Part D, as well as nursing home care and Managed Long Term Services and Supports (MLTSS) under the state's 1915(c) waiver for home and community based services. Enrollment in MSHO is voluntary. MSHO started as the first integrated Medicare Medicaid demonstration approved by CMS in 1995 and transitioned to D-SNP status with the implementation of Medicare Part D in 2005 and 2006. MSHO operates statewide. While MSHO members are generally representative of FBDE seniors in Minnesota with enrollment of over 70% of all Medicaid seniors, MSHO attracts a slightly disproportionate share of frail elderly compared to the total seniors' population eligible and required to enroll in Medicaid managed care in Minnesota.

The average age of enrollees in MSHO is 81. MSHO serves Medicaid seniors at all levels of care and in all settings. However, a large majority (about 81%) of MSHO enrollees meet additional qualifications for MLTSS or nursing home services based on impairments in activities of daily living (ADLs) and other frailty factors. About 45% of MSHO community members reside in the community and meet ADL and other requirements to receive home and community based waiver services under §1915(c) that are designed to keep them out of nursing homes. Another 25% meet the same level of care qualifications and reside in nursing homes. The remaining members (about 30%) reside in the community and do not receive home and community based waiver services. However 11% of that group also qualifies for personal care services that provide ADL assistance through the Medicaid state plan benefit. Therefore, a total of about 81% of all MSHO members require some form of long term personal assistance either in the home or a nursing home.

All MSHO D-SNPs are also required to offer Minnesota Senior CarePlus (MSC+) which serves about 11,000 dual and 2,000 non-dually eligible seniors 65 and older including those dually eligible who have not chosen to enroll in MSHO. Enrollment in MSC+ is mandatory; however people with dual eligibility are allowed to opt out by choosing MSHO enrollment instead. MSC+ covers all of the same Medicaid services as MSHO, and also enrolls people in all settings of care, but is not integrated with Medicare. Enrollees must choose a separate Part D plan and care coordination models differ due to the inclusion of Medicare in MSHO. Members who remain in MSC+ have slightly different characteristics from MSHO's D-SNP population. Overall, a total of about 69% of this group uses MLTSS

services. MSC+ members tend to be younger (average age 78) and use less institutional and home and community based waiver services. (19% reside in nursing facilities and about 36% receive home and community based waiver services in their homes.) About 45% reside in the community but do not receive home and community based services under 1915 (c); however about 14% of that group also uses state plan personal care.

In addition, both the state and Medicare have contracts under separate H numbers with two other D-SNPs for different dual eligible subset designed for FBDE people with disabilities age 18-64 under the Special Needs BasicCare (SNBC) program. SNBC provides most state plan Medicaid services including behavioral health, but does not include LTSS and personal care services which remain fee for service for those enrolled. While SNBC enrolls about 49,000 dual and non-dual people with disabilities through 5 Managed Care Organizations (MCOs) only about 1,100 are enrolled in the two D-SNPs for both Medicare and Medicaid.

It is important to note that demographic profile of dual eligibles enrolled in MSHO are very different from those enrolled in SNBC because of the differences in underlying characteristics of the populations served. Neither program is representative of the total population of dual eligibles which includes a wide range of ages and conditions. This illustrates the fact that choices made by states in the design of their population subsets under contracts with D-SNPs greatly influence the underlying demographic characteristics of the populations served. Those characteristics are largely outside of the control of the plan but may lead to differences in health outcomes.

Much research has been done that indicates a relationship between demographic and socioeconomic factors and health outcomes. CMS must consider differences in these underlying characteristics when measuring outcomes, comparing plan performance, and assessing performance for bonus payments. Risk adjustment to account for these underlying differences in demographics and socioeconomic factors is necessary to distinguish between poor performance and differences in populations served.

2. Memorandum of Understanding for an Administrative Alignment Demonstration for MSHO Beneficiaries

Because Minnesota sponsored the first integrated state Medicare Medicaid demonstration approved by CMS in 1995, MN D-SNPs have had many years of experience integrating administrative functions for enrollees. The MSHO D-SNP program has served as a model for other integrated programs including recent efforts at CMS to expand integrated programs through the Financial Alignment Demonstration (FAD). MN submitted a proposal to participate in these new demonstration opportunities, but there was mutual agreement that the FAD would not work for D-SNPs in Minnesota. Instead, CMS and MN entered into a Memorandum of Understanding (MOU) for a separate "Administrative Alignment" demonstration retaining the current D-SNP platform. This demonstration covers seniors enrolled in 8 D-SNPs under MSHO. This demonstration specifies opportunities to work with CMS to improve measurement used in Star ratings. These comments reflect some of the concerns and suggestions we wish to bring forward as part of that MOU effort. MN DHS will continue to refine its recommendations related to the MOU, including those submitted here, through the Contract Management Team (CMT) provided through the MMCO.

3. Clinical Workgroup

These comments and recommendations reflect many hours of discussion with clinical experts in Minnesota. The state convened an expert panel of D-SNP Medical Directors, geriatricians and quality assurance staff to discuss and advise on comments and recommendations for this effort and for our related MOU initiative. The workgroup voiced strong concerns that current Stars measures are not reflective of the needs of MSHO beneficiaries and require revisions to make them relevant and useful for this population. They believe that comparisons between MA plans including D-SNPs requires risk adjustment of measures including stratification by age bands, institutional and LIS status in order to assure that Star ratings reflect differences in performance rather than differences in populations served. They also suggested areas where measures should be modified, dropped or added to better reflect the nature of care required for populations served under FIDE SNPs.

4. Summary of Issues

- CMS uses Star ratings for several purposes. Measurement of performance of Medicare Advantage plans, a tool for beneficiaries for comparison of performance between plans, and for administering pay for performance bonus payments based on quality. All of these purposes require fair comparisons that reflect actual performance, and that distinguish between poor performance and underlying differences in demographic or socio-economic status of the target population of beneficiaries served under the plan.

- While not all measures may require risk adjustment for such factors, the National Quality Forum has recommended that performance measures be assessed to indicate where risk adjustment is appropriate and that adjustments be made accordingly. In a technical report "Risk Adjustment for Socioeconomic Status or other Sociodemographic Factors" issued July 2, 2014, the National Quality Forum (NQF) indicates that risk adjustment is appropriate if the intent is to answer the question "how would the performance of various units compare if hypothetically they had the same mix of patients?" This is the question that CMS should be asking as it reviews its Stars measurement system.

- The mix of patients served under MSHO is significantly different from other Medicare plans. Most of the differences are related to MSHO's serving a dramatically different age and stage of life profile from most Medicare plans including other D-SNPs who may serve large numbers of younger duals. While all MA plans likely serve some members that look like MSHO members with regard to these factors, relatively few plans (PACE and a handful of FIDE SNPs) focus exclusively on the frail and very old elderly whose characteristics combine very advanced age, higher rates of dementia, high levels of need for end of life and palliative care, high levels of ADL impairments and need for home and community based services, along with poverty, lower rates of high school education and high levels of institutionalization. CMS policy requirements are designed to allow plans and states to serve these dual eligible "subsets" and to define those differently from the broader populations served by other MA plans (for example all dual eligibles versus other MA populations, or dually eligible seniors 65 and older versus dually eligible people with disabilities under age 65). Since CMS policy allows these subsets, quality measurement should also follow suit and anticipate the need for risk adjustment for fair comparison of like populations in keeping with the NQF principle above.

- A recent and extensive Inovalon study finds that overall, dual eligibles score worse on Star measures when compared with other Medicare beneficiaries. (Inovalon, Part 1: Member Level Analysis, October 2014). The study outlines how underlying socioeconomic and demographic differences result in lower Stars scores for dually eligible members. This study also provides some evidence that plans serving large numbers of dual eligibles (90-100%) perform better on many Star measures than plans with smaller numbers of dual eligibles. Consistent with that study, MSHO D-SNPs, all of whom serve 100% dually eligible seniors, have historically scored higher than average on overall Star ratings despite often dramatic statistically significant differences in socio demographic and economic status of their enrollees compared to enrollees in plans that serve a typical Medicare population. MN D-SNPs also historically have had low disenrollment rates, low rates of grievances and appeals and have scored higher than other Medicaid plans in Minnesota on most CAHPS measures.

- However, MSHO D-SNPs are also MLTSS plans with detailed Medicaid contracts requiring a high level of integration between Medicare and Medicaid. They have many years of experience serving highly frail seniors under a host of additional contract requirements. Achieving current performance levels has required immense commitment from MSHO plans to high staffing levels, staff training, community investments and additional administrative expense. Unlike most other Medicare plans, MSHO plans must meet all additional CMS Model of Care requirements for D-SNPs as well as all of Minnesota's extensive Medicaid contract requirements for MLTSS plans and FIDE SNPs. MSHO plans are responsible for comprehensive assessment of all members, individualized care plans and individual care coordinators for all members, interdisciplinary care teams, integration of materials, integrated enrollment systems, integrated Medicare and Medicaid member services and call centers, integrated benefit determinations, integrated HIT mechanisms, integrated provider billing and claims adjudication systems, payment for health care homes, management of extensive MLTSS networks including a huge array of assisted living facilities, transitions of care protocols and reporting, increased use of physician extenders in nursing home and post-acute care services, behavioral and physical health coordination, pay for performance projects, community outreach, health literacy and member engagement strategies, Minnesota specific disease management requirements, Medicare and Medicaid quality assurance plans and

performance improvement projects, care plan audit protocols and reports, submission of all encounter data (separately) to Medicare and Medicaid and implementation of Minnesota specific health and MLTSS reforms.

- While MSHO FIDE SNPs may serve duals better than some other MA plans serving duals, as outlined above, this takes great effort, and we are concerned that in general D-SNPs focusing on dual populations, including Minnesota's MSHO plans, face a systematic disadvantage in Star ratings due to the differences in the populations they serve, resulting in penalties and disincentives compared to plans that serve a more typical distribution of Medicare members. Despite the additional interventions and contract requirements, on most Star measures MSHO D-SNPs still have lower average Star scores than other MA products offered in Minnesota under the same plan sponsors. We believe these differences are driven by a different "mix of patients" as evidenced by differences in demographic and socioeconomic status and rates of chronic disease.

- Our analysis of CMS data on Stars for all Minnesota plans indicates that Minnesota plan sponsors who have both an MSHO FIDE SNP and a MA-PD or Cost Plan, typically score worse on their MSHO D-SNP than on their MA-PD or Cost plans overall. This is consistent across all four plans with both products and further supports an argument for risk adjustment by age bands and LIS and institutional status or similar mechanisms that address a very different mix in the underlying population. Further, with recent and proposed changes in Star ratings methodologies (eliminating thresholds and changes in cut points) overall MSHO D-SNP Star performance has dropped and is expected to continue to drop in future years.

- It is also important that quality measurement for these plans be revised to increase their relevance to the populations served. Clinicians involved in MSHO expressed serious concerns that the current array of Star measures applied to MSHO D-SNPs does not address the needs of the members served. The current rating system does not focus on measures specific to populations served within D-SNPs and services that D-SNPs are specifically responsible for, and lacks any measures around complex chronic care management, palliative and end of life care, care transitions and coordination of community and medical services which are at the heart of the additional services FIDE-SNPs are required to provide.

- They are concerned that if measures are applied that do not "fit" the needs of the population, there will be unintended consequences. For example, clinicians may be pressured to achieve high performance through application of measures that are inappropriate to MSHO members requiring end of life care due to their age, multiple chronic conditions and expected life span. Or clinicians may be forced to spend time trying to improve scores for measures of minimal value to the population due to small numbers of members with that condition (for example ART), or meeting benchmarks requiring compliance that is not achievable for patients with high levels of dementia. At the same time, D-SNPs are investing in significant interventions to serve members that remain unexplored or unrecognized in any measure, such as individualized care planning, advanced directives, individual care coordination and communication between care coordinators and primary care. Further, stakeholders have questioned whether the current measures reflect priorities of beneficiaries and their families.

- While overall measurement should continue to be improved to assure fair comparisons that can indicate true disparities in service among all beneficiaries, Star measures are also used as a pay-for-performance mechanism. For fairness in use as a pay-for-performance mechanism, measurement must assure comparisons that distinguish between actual poor performance versus inherent challenges in serving populations with complex needs, low literacy, and other socio-economic issues. D-SNPs are designed to serve exactly those populations, and are held to additional requirements and incur additional expenses to meet those needs. They should not be financially disadvantaged compared to the universe of all MA plans simply because they have chosen to serve populations with more complex and diverse health challenges. The current Stars system does not make that distinction. Based on publicly available research and states' on-the-ground experience working with D-SNPs, we believe the existing structure of the Star rating system disadvantages these plans and beneficiaries in them, who might benefit from higher Stars related payments.

5. Summary of Recommendations

- To address these issues, at minimum, as recommended by NQF, CMS should develop and implement risk adjustment and or stratification mechanisms for Star measures, that will better distinguish between underlying demographic characteristics and poor performance.
- CMS should review Star measures to identify where age bands or stratification by peer group (LIS/non LIS status or institutional vs non institutional status) should be applied as part of this risk adjustment.
- CMS should also consider dropping or modifying some measures, and adding others as recommended under section C. below.
- In addition, information should be collected at the PBP level instead of the contract level to better reflect experience of D-SNP members.
- CMS should also consider removing financial disincentives for D-SNPs to cover Part D co-pays.
- CMS should also consider changes in CAHPs and HOS to improve the quality of responses on HOS and CAHPS questions based on health literacy research indicating that frail elders and people with disabilities have difficulty with the current design and scaling of questions. CMS should also expand the number of languages in which these surveys are available.
- CMS could also test some of these changes as part of its alignment demonstration under Minnesota's MOU as noted in subsequent sections of this submission.

The following sections provide more supporting information and specific details on these recommendations.

B. MSHO DEMOGRAPHICS

1. Comparison of MSHO Age to Medicare, MA PDs and All Dual Eligibles

Demographics of the MSHO population differ from the overall dual eligible population, and from the overall Medicare and Medicare Advantage populations. D-SNPs are required to have contracts with states, but CMS policy allows states and D-SNPs to focus on population subsets to align Medicare and Medicaid enrollment. MN has chosen to enroll only FDBE seniors age 65 and older in MSHO so nearly 100% of MSHO enrollees meet this requirement (D-SNPs are required to continue coverage for members who lose dual status for up to 6 months but in MN all have agreed to cover up to 3 months so a few non-dual members may retain coverage during the transition.) 48% of MSHO enrollees are over the age of 80, while nationally only about 23% of all Medicare beneficiaries and 22% of all MA-PD enrollees are over age 80. 65% of MSHO enrollees are over age 75, the exact opposite of the total dually eligible population in which about 69% are under age 75. The following charts indicates the percentage of each group in all Medicare, all MA-PD and MSHO as well as the percentage of each group for all dually eligible populations compared to MSHO.

Age	%Medicare	%MA–PD	%MSHO
<65	19	15	0
65–69	26	26	16
70–74	19	21	19
75–79	14	16	17
80+	23	22	48

Source: Medpac June 2014 Data Book, MSHO Enrollment files 2014

Age	%All Dual Eligibles	%MSHO
>65	45	0
65-74	24	35
75-84	19	33
85+	12	32

Source: MedPac, June 2014 Data Book, MSHO enrollment files 2014

These demographics illustrate how state contract decisions around dual eligible subsets drive underlying demographic factors of D-SNP plans. CMS should not assume that all dual eligibles have the same needs and that all D-SNPs serve the same populations. CMS should assure that appropriate risk adjustments are applied to account for

underlying differences in population characteristics that influence trajectories and outcomes of care such as age, end of life stages, institutional status, and LIS or dual status. However, risk adjustment based on dual status alone will not accommodate those differences, since states are allowed choices in how they contract with D-SNPs and may choose to contract to serve dual eligible subsets with different characteristics.

2. Chronic Disease and Institutional Comparisons (Appendix 1.)

In addition to the demographic differences in populations served by MA plans compared to MSHO plans, chronic disease rates in MSHO D-SNPs are higher than the average of Medicare beneficiaries age 65 and older according to data from the CMS chart book, 2012 edition. MSHO rates of arthritis are over 40% compared to 31% in other Medicare beneficiaries over age 65. Heart failure rates in MSHO are 21.1% versus 17%. Diabetes rates are 36.2% versus 28%. Depression rates are 64% in MSHO versus 12%. Presence of stroke is 29% in MSHO versus 5%. Alzheimer's/ Dementia rates are 24.5% versus 13%. Appendix 1 includes charts showing the top diagnoses groups for MSHO enrollees. (Sources: MSHO integrated Medicare Medicaid encounter claims 2013, MN DHS MMIS system, Chronic Conditions Among Medicare Beneficiaries, CMS chart book 2012 edition).

The proportion of MSHO members residing in nursing homes is also dramatically different from the overall Medicare average of less than 4%. About 23% of MSHO residents reside in nursing homes at any given time. While this number is significantly different from the Medicare average, this number has declined from 60.6% of all Medicaid seniors in 1996 and MN's long term nursing home utilization is now lower than typical for most dually eligible populations. During that same period the proportion of the population receiving community services has risen from 9.4% to 42% and the state has "rebalanced" its institutionalization vs community service rates for Medicaid seniors. ARRP has ranked Minnesota's long term services and supports #1 in the nation for the past two years. All Medicaid community enrollees are screened and assessed for eligibility for home and community based services under MSHO and those eligible have immediate access.

As noted above, dementia rates in MSHO are also substantially higher (24.5%) than the average prevalence among Medicare beneficiaries over 65 (13%). Dementia rates are highly correlated with age and higher rates of hospitalization and institutional use. MSHO enrolls a much higher number of people over age 80 (48%) than typical Medicare plans. In addition, 53% of MSHO members residing in nursing homes have a diagnosis of dementia/Alzheimer. Medicare beneficiaries age 65 and older with dementia are more likely than other beneficiaries to also have other chronic conditions, and dementia exacerbates the difficulty of managing coexisting chronic conditions. (2014 Alzheimer's disease Facts and Figures). Presence of dementia can also impact responses on HOS.

3. HOS Response Comparison (See Appendix 2.)

Given the importance of self-reported information collected through HOS on the Stars ratings, we collected HOS data response information from each MSHO D-SNP in Minnesota to compare the characteristics of their MSHO respondents with the national HOS sample characteristics. Assuming HOS responses are valid representations of MSHO members; this analysis further illustrates the differences between MSHO population and the national beneficiary respondents. It also reflects significant differences in socio economic status (SES) and Socio-Demographic Status (SDS) likely to influence health literacy and therefore the nature of the responses. We are concerned that the HOS samples are not comparing like populations and that underlying differences in the populations may drive responses, rather than indicate quality differences attributable to care under the MSHO plans.

Key statistically significant results (using base line data) indicate that MSHO respondents are much older (45% are 80 and older vs 8% in the national sample), more likely to be female (77% vs 58%), more likely to be widowed, divorced, separated or never married (80% vs 43%), and much less likely to have a high school education. Of course, since all are dually eligible, they are much more likely to be in households with annual incomes of less than $10,000 (52% vs 11%). Similar differences hold true for the follow up sample. All of these factors have been cited in various studies indicating the importance of SES and SDS impacts on health outcomes and health literacy.

Appendix 2 includes demographic comparisons of the MSHO D-SNPs sample versus the National Medicare Advantage samples for HOS. There is a tab for each health plan with the demographic data that they provided to us. There is a tab called 'MN' which includes an aggregated group of all the data for Minnesota compared to the

National sample. Chi-square statistics were calculated for each demographic variable and the results indicated that the Minnesota sample was highly significantly different from the National sample in regard to the distribution of each of the demographic characteristics. Cohen's *h* effect sizes were calculated to identify the categories for each demographic variable that were driving the difference between the groups. Cohen's *h*, can be interpreted as follows: An effect size greater than or equal to .20 and less than .50 is consider a small effect (small effect sizes are in bold); an effect size greater than or equal to .50 and less than .80 is considered a medium effect size (medium effect sizes are highlighted yellow), and an effect size greater than or equal to .80 is considered a large effect (large effect sizes are in red font). If the effect size is negative it means that the proportion of Minnesota's sample is smaller than the proportion of the National sample for the characteristic, and if the effect size is positive it means the proportion of Minnesota's sample is larger than the proportion of the National sample for the characteristic.

The last tab contains tables for the SES and SDS characteristics we believe are most salient to explain the differences in Stars ratings between MA-PDs and MSHO plans nationally and within MN (i.e., % 80+, %85+, % female, % widowed or divorced, % did not graduate from high school, and % with an annual income < $10,000), and the data is broken out by plan versus the national sample. We have also included the data for the Minnesota total, which is all the health plans combined.

These differences in SES and SDS factors indicate additional challenges MSHO plans face in serving a dually eligible population that is older and more frail than typical Medicare beneficiaries and further argues for age or other stratification to better target performance measures that truly indicate differences in care and outcomes, versus simply reflecting different demographic and economic status. Comparison of the MSHO population to typical MA-PDs who have an entirely different and younger, more healthy distribution of members confuses performance differences with differences in the underlying characteristics of the population. Similarly, comparison of MSHO to plans with typical distributions of dual eligibles will also mask true differences in quality and performance, because the overall dual eligible population includes large numbers of enrollees under age 65 whose needs and appropriate benchmarks may differ.

C. MSHO STARS PERFORMANCE AND ANALYSIS

1. Average Star Scores for MA vs MSHO in Same Plan (See Appendix 3.)

In Minnesota, due to the state's mandatory enrollment for FBDE in managed care and high Medicare premiums for most MA-PDs and Cost Plans, only a handful of dual eligibles are enrolled in regular MA plans. In addition, all but one of the MSHO plans has its own H number, reflecting only MSHO PBP data on Stars. (One plan also includes a few thousand members from a different Medicare product in its MSHO H number though that will cease in 2015). We determined that a comparison of MA/Cost plans Part C scores with MSHO plan Star Part C scores under the same plan sponsor could be useful in controlling for the extraneous influences on outcome measures, thus isolating the effect of providing services to a dual versus non-dual population.

Using the public data on Part C Stars scores for 2103, 2014, and 2015, we calculated the odds of meeting the criteria measured by Star items and compared the four Medicare plans to the four MSHO D-SNPs within the same health plan sponsor. (Note: the odds were also included for the MSHO D-SNPs whose health plan sponsor did not have a Medicare plan in order to further describe the MSHO D-SNP population.) Subsequently, we calculated odds ratios in order to obtain an effect size of the discrepancies between products for each health plan sponsor.

Appendix 3 contains a PDF file with the calculated odds for each product within each health plan sponsor and an odds ratio for comparison of MSHO vs MA Cost/HMO product data on Part C Stars measures for each of the four plans that have both products over three years 2013, 2014 and 2015. The Y axis for each chart indicates the odds that an enrollee in a product will receive the service specified in the stars measure (e.g., breast cancer screening, colorectal cancer screening). If the odds equal 1, then that means for every 1 person that met the criteria 1 person did not meet the criteria. If the odds are 2, then for every 2 people that met the criteria 1 person did not. If the odds are less than 1, then less than half of the enrollees for the product met the criteria. The health plan indicator (Plan A, B, etc.) appears along the X axis along with an odds ratio comparing MSHO to the Cost/HMO plan. An odds ratio of 1.00 indicates that MSHO and the Medicare product had equal proportions of enrollees meeting the criteria, an odds

ratio greater than or equal to 1.50 indicates that the Medicare product had a greater proportion meeting the criteria, an odds ratio less than or equal to 0.7 indicates that MSHO had a greater proportion of enrollees meeting the criteria, and odds ratios ranging from 0.71 to 0.99 and 1.01 to 1.49 indicate that MSHO and the Medicare product were not exactly the same but were not substantively different. The further the value of the odds ratio is away from 1 the larger the difference between the two products.

While there is some fluctuation in measures between the years and between plans, in general, MSHO scores lower on the following measures (Odds ratios consistently greater than 1.5):

- Breast Cancer Screening
- Colorectal Cancer Screening
- Cholesterol Screening (for both diabetes and cardiovascular care)
- Osteoporosis management for women
- Rheumatoid Arthritis Management
- Customer Service

MSHO plans score better than the Cost/HMO products on the following measures, (Odds ratios consistently smaller than .7):

- Reducing the risk of falling
- Improving bladder control (does better or equivalent)

MSHO and Cost/HMO products score about the same on the following measures, (Odds ratios consistently between .7 and 1.5):

- Flu vaccines
- Improving or maintaining physical health
- Monitoring physical activity
- Diabetes care – eye exam
- Controlling blood pressure
- Improving or maintaining mental health
- Rating of Health Care Quality
- Rating of Health Plan
- Members choosing to leave plan

As indicated in the chart below, during the past three years, with one exception, (Plan B in 2015) MSHO plans score about .5 lower on most Part C measures than do other MA plans offered by the same plan sponsor. This results in a similar difference in final overall scores. Even though MSHO plans are investing significant additional resources in care coordination, member services and care management and are subject to many more contract requirements designed to improve the quality of care, MSHO plans do not seem to be able to reach the same levels of Stars performance of the other MA products offered by the same sponsor. All of these plans meet the same basic state licensing requirements for risk bearing entities. MSHO plans also meet significant additional requirements from both Medicare and Medicaid. It is fair to conclude that a major reason for this systematic difference in performance within the same plan sponsor is related to differences in the underlying demographic and socioeconomic characteristics of the populations served.

Summary Star Ratings for Part C, Part D, and Overall

Product	Health Plan	SNP	Part C Summary Rating 2013	Part C Summary Rating 2014	Part C Summary Rating 2015	Part D Summary Rating 2013	Part D Summary Rating 2014	Part D Summary Rating 2015	Overall Summary Rating 2013	Overall Summary Rating 2014	Overall Summary Rating 2015
Cost/HMO	Plan A	No	4.5	4	4						
MSHO	Plan A	Yes	4	3.5	3.5	4	4	3.5	3.5	3.5	3.5
Cost/HMO	Plan B	No	5	5	4.5	4.5	4.5	5	5	4.5	4.5
MSHO	Plan B	Yes	4.5	4.5	4.5	4.5	4	4	4.5	4.5	4.5
Cost/HMO	Plan C	No	5	4.5	4.5	4.5	4	5	4.5	4.5	4.5
MSHO	Plan C	Yes	4	4	4	4	3.5	4	4	4	4
Cost/HMO	Plan D	No	4.5	4.5	4	4.5	5	4.5	4.5	4.5	4.5
MSHO	Plan D	Yes	4	3.5	3.5	3.5	4	3.5	3.5	4	3.5
MSHO	Plan F	Yes	4	4		4	3.5		4	3.5	
MSHO	Plan E	Yes			4	4	3.5	3.5			4
MSHO	Plan G	Yes					4	4			
MSHO	Plan H	Yes	3.5	4	3	4	4	4	4	4	3.5

Notes. Plan F is dropping out of the market in 2015.

The chart below reflects the average difference of .5 in the overall D-SNP Star ratings relative to the non-D-SNP plans in the same plan sponsors. None of the other MSHO D-SNPs which do not sponsor other products exceed 4 Stars, and on average their scores are slightly lower than the four plans that also sponsor Cost/HMO products. It should be noted that three of those plans (E, G and H) exclusively serve rural areas.

Average Difference Scores for Plan with Both MSHO and a Cost/HMO Product

Year	Part C	Part D	Overall
2013	-0.63	-0.50	-0.67
2014	-0.50	-0.67	-0.50
2015	-0.38	-1.00	-0.50

2. Performance Improvements and Disparities

a. Consistency with Inovalon Study

The results for specific measures indicated above are consistent with findings of the recent Inovalon study, which indicates lower performance related to dual status on some of the same measures (Inovalon, Part 1: Member Level Analysis, October 2014). This study found that older duals age 80 -84 perform about 11% worse on Rheumatoid Arthritis management (ART) than non-duals in that age group. They also found that dually eligible women age 70-74 and those in small or isolated rural areas (most of MN is rural) have fewer Breast Cancer Screenings (BRC) and do worse on that measure than non-duals.

Consistent with the Inovalon study, MSHO plans also do worse than non-duals on High Risk Medications (HRM) another measure for which performance of the Cost/HMO products is significantly better and which has a high correlation with age, frailty and institutional status. Inovalon found that duals in rural area and duals in plans serving the highest and lowest proportions of duals do more poorly on this measure. (All of the MSHO plans serve nearly 100% dually eligible populations.) Consistent with that finding, smaller rural plan (E and H) have more

fluctuation and lower performance in general on this measure. These two plans also have higher overall rates of institutional use due to age and provider differences in their service areas. Plan G is also small and rural, but has lower institutional use.

The study also found that dual eligibles do worse on Plan All-cause Readmissions (PCR). MSHO plans overall have lower rates of PCR than duals with similar age ranges in the Inovalon study, and on average have been reducing those rates each year below the benchmark of 13%. However this is one of the few measures that is risk adjusted for characteristics that would be applicable to MSHO plans, illustrating how appropriate risk adjustment may produce more fair comparisons for this population.

3. Relevance of Performance Measures

a. Measures to eliminate or adjust

Our clinical advisory group spent considerable time considering which measures are most appropriate for people with dual eligibility and the specific population served under MSHO. They recommended that several measures be dropped or age adjusted and that other measures that can drive best practices on key care delivery and management issues across larger groups of seniors be added instead.

- **Rheumatoid Arthritis Management.** This measure is directed at the percent of plan members with RA who got one or more prescriptions for an anti-rheumatic drug. A major problem with this measure is its narrow scope and small numbers. While the prevalence of arthritis among the MSHO population is relatively high, this form of arthritis is not as common and involves few members. Some medications may also be contraindicated for very old members. Thus, this measure is not very useful for the MSHO population and resources would be better spent on conditions that impact more members. Alternatively this measure could be age banded, but that would reduce the numbers even further. CMS should consider a review of measures affecting small numbers of members. Minnesota has contracted only with local non-profit plans, many of which are small and serve rural areas. Since the dually eligible population is smaller and requires more specialized care models than the overall Medicare population, D-SNPs in many states will never reach the large numbers anticipated in average MA-PDs.
- **Colorectal Cancer Screening:** While this is an important measure for most populations and does not apply to members 75 and older, our clinicians recommended that consideration be given to exclusions based on permanent institutional status and people receiving end of life care.
- **Breast Cancer Screening:** Again, clinicians recommend exclusion for people in end of life care or permanent institutional status. This is even more important as the upper cap is extended to 79.
- **Osteoporosis:** Many medications used in the treatment of osteoporosis require that a member cooperate with their tests (for example remain still in an MRI machine), understand their care plan and comply with their medications (for instance sit upright for several hours after taking the medication). The MSHO population includes disproportionate numbers of seniors with dementia. Many seniors with severe dementia or in end of life care are not able or willing to do this and may actually be frightened by such tests. To some extent this measure also is targeted at small numbers of members. Excluding institutional populations or application of age banding would improve the accuracy and utility of this measure.

b. Other adjustments:

Annual Flu Vaccine: We also recommend that CMS modify the Annual Flu Vaccine measure to align with the HEDIS reporting requirements rather than using CAHPs as the source of data. Especially for an older population, CAHPs is not a reliable data collection tool for such tests. While it is true that members may obtain flu shots that plans cannot track in their claims data, plans are more likely to be able to document accurate receipt of annual flu vaccines for members, and their sources are likely to be more accurate that what is provided in CAHPS data for dual populations.

c. Additional measures to consider:

Our clinical advisors also expressed concern that measures that should be considered for special needs populations are not reflected in the current Stars measures and that plans spend large amounts of time and effort on areas that are not recognized in bonus payments. They recommended that CMS consider additional HEDIS or MDS measures including:

- **Advanced Care Planning:** A huge amount of time is spent by MSHO care coordinators and clinicians assuring that members have advance directives that reflect their wishes for care and treatment should they become ill or have an emergency. While there is a HEDIS measure already collected on this item, the clinical workgroup prefers a measure developed by Minnesota Community Measurement. We would be glad to share more information on this measure.
- **Medication Reconciliation Post Discharge:** This is a HEDIS SNP measure and addresses an issue related to safe transitions that clinicians regard as critically important.
- **Use of anti-psychotics for people with dementia in institutions:** This is a critical issue for older seniors in nursing homes especially and one to which our clinicians are committed to improve. There is an existing MDS measure that could be adapted or applied to SNPs that would address this gap in measurement.

d. Measure Development Needed

CMS also should consider additional measures as discussed by our clinical advisory group related to Presence of a Care Plan and Sharing of Care Plans between care coordinators and primary care physicians and clinics such as health care homes. While measures in these areas would be considered process measures, they reflect major regulatory requirements that CMS has applied to SNPs and are directly related to outcomes of care. Clinicians emphasized that it is very hard to develop appropriate benchmarks on frail seniors and people with multiple co-morbid conditions, many of whom require end of life care and have complex medical needs that cannot be treated with standard medical protocols. Their advice is that disease specific outcome measures are not useful in this population and that process measures related to person centered care planning and communication between providers are more valuable indicators of good care in these cases. As outlined earlier, MSHO D-SNPs spend a huge amount of time and resources in these endeavors but there are currently no measures that reflect these activities.

As part of the MSHO demonstration, DHS agreed to work with CMS to test additional measures related to the MLTSS needs of members. We were advised that the MSHO demonstration might be most useful in helping to identify important intersections between primary care paid through Medicare and community based or long term care facility services paid through Medicaid.

For example, CMS and MLTSS states both require assessment and care plans for D-SNP members and conduct audits on care plan requirements. It is important that these activities be coordinated and not duplicative and confusing to frail beneficiaries. CMS has already added an assessment measure to the Star ratings measures, also a process measure. Care planning is an area where Medicare and Medicaid need to intersect to assure that care in both systems is coordinated and efficient. Both programs also require care coordination, which includes identifying members of an Interdisciplinary Care Team (IDCT). Communication between IDCT members including care coordinators responsible for MLTSS and or SNP Model of Care activities is crucial. DHS and clinical work group members have looked for approved measures in these areas, but have not found them at this point. We are developing some preliminary specifications for such measures that would require additional development. This is an area we would like to continue to explore with CMS through the MMCO CMT.

e. Collection of Performance Data at the PBP Level

Appropriate evaluation of D-SNP performance is currently limited due to the collection of data at contract vs PBP levels. Contracts may include various PBPs under the same H number. Collection of CAHPS and other Stars data elements which combine several products are not useful in meaningfully measuring performance of important subsets of the Medicare population such as dual eligibles and in applying the risk stratifications recommended by NQF. In addition, States are also required to collect CAHPS and HEDIS data for Medicaid purposes and ideally there would be efficiencies in merging these requirements or in the state being able to utilize the Medicare

submissions. However, this is not possible in many cases because contract data may include other products that do not reflect the population served under the state contract. The state then must require duplicative HEDIS and CAHPs reports and the result is inefficiency for all parties.

HOS might be one of the few sources of data available that captures some of the socioeconomic variables that might be useful for risk stratification. While we do not think self-reported data is the best source for this information due to high levels of dementia and mental impairment in an older MSHO population, right now it might be the only meaningful source available within Medicare reporting structures and so could be considered. However, it would need to be collected at the PBP level as well.

f. Allow Plan Buy Down of Pharmacy Co-Pays

While plans operating under PACE and FAD programs are allowed to waive or buy down Part D drug-copayments, D-SNPs serving the same populations would have to accept a reduced LIS subsidy to do so. Plans serving 100% dual eligibles in particular face financial disincentives in doing this. There is ample research to indicate that even at low levels, these co-pays are an added barrier to dual eligibles, who already face disproportionate economic, health literacy and cognitive challenges to medication adherence, and can have negative impacts on health outcomes. Part D co-pays are already waived for people in institutional settings. Yet, people at that same level of care who choose to stay in their own homes and receive care are not able to access the same level of benefit.

As part of its MOU with CMS, DHS proposed that MSHO plans be allowed to buy down Part D drug co-payments. This was not part of the final waivers provided in the MOU. However the MOU contains the following statement: "This Demonstration does not change current benefits or medical necessity determination criteria for MSHO Enrollees, except that CMS will work with the State to explore options for MCOs to reduce Part D co-pays for all enrollees as a way of testing whether reducing enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the Demonstration. Any changes would be incorporated into the annual bid process and subject to CMS approval and be implemented no earlier than the MSHO SNP 2015 contracting year." DHS will welcome further discussions with CMS on how this demonstration may be useful in testing buy down of Part D co-payments,

4. HOS/CAHPs/Health Literacy for Elderly

CMS Medicaid has recently issued TEFT (Testing Experience and Functional Tools) grants related to National Quality Strategy priorities for a HCBS experience survey of people receiving Medicaid home and community based services and supports. This survey is following CAHPS principles and is being tested for use. Question designs and frequency scales are being tested with attention to people with disabilities, cognitive impairments including dementia, health literacy challenges and ESL. Application will be made to NQF for endorsement when finalized. Researchers report significant difficulty for some populations in following traditional CAHPs questions and designs.

An in person study done among frail elders participating in home care programs in Connecticut illustrated these difficulties by publishing narrative results of conversations with elders who were asked CAHPs questions about their care and services and satisfaction with physician and other services. The recorded conversations indicated that a large number of the interviewees lacked ability to comprehend the questions, had hearing difficulties, and gave inappropriate answers in response to scaling and question design. Examples include: Question-on a scale of 1-10, how would you rate your physician? Answer " Excellent". Question- How many times did you visit the doctor in the past six months? Answer: "I go when I need to". "Survey of the Pilot Test of a Consumer Survey Among the Connecticut Home Care for Elders Program", New England States Consortium, Cynthia Gruman, PHD, University of Connecticut.

CMS should pay particular attention to learnings from these studies about scaling and question design which might be useful for future adjustments in CAHPs and HOS for Medicare Medicaid integrated MLTSS programs serving high needs members such as MSHO.

CMS relies heavily on HOS data for several Stars elements, even though self- reported data may not be the best source of data for many of those questions and other data sources exist. For example, states collect substantial data

related to health status (ADLs, IADLs, long term nursing facility use) that is accepted by CMS Medicaid and used for Medicaid payments for long term care services for the same populations served by D-SNPs. HOS samples may not be reflective of D-SNP populations who are institutionalized, have dementia, intellectual or developmental disabilities, and mental illness.

Further, similar to the CAHPs issues above, design of HOS questions is often confusing to these groups. Proxy methodologies are not well controlled, meaning that nursing home or other provider staff may submit answers for beneficiaries. Scaling is limited and may not reflect variations important to the member. The survey relies on memory for key answers, such as rating of health compared to a year ago or numbers of days of good health.

CMS should undertake a comprehensive review of the HOS survey using research such as that cited above, geriatric and disability expertise and researchers familiar with scaling and question design and appropriate proxy methodologies for frail elderly and people with disabilities.

Further, some plans have high numbers of dually eligible members who end up being excluded from both HOS and CAHPs surveys because surveys are generally not available in languages other than English, Spanish or Mandarin. Even in Minnesota D-SNPs in metro areas serve large numbers of immigrant seniors who speak Hmong, Vietnamese, Somali and Russian and views of these members may not be reflected in these important surveys. Under Minnesota's MOU we have proposed that HOS be translated into Somali and we continue to work with the CMT on that initiative. CMS should consider additional translations and methods of reaching non English speaking members for these surveys.