HealthPartners
8170 33rd Avenue South
Bloomington, MN 55425

healthpartners.com

Mailing Address:
PO Box 1309
Minneapolis, MN 55440-1309

November 3, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
750 Security Boulevard
Baltimore, MD 21244-1850

RE: Request for Information—Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees

Dear Administrator Tavenner:

HealthPartners appreciates the opportunity to comment on the impact of Special Need Plan (SNP) status o the CMS Stars measures and ratings.

Founded in 1957, HealthPartners is the largest consumer-governed, non-profit health care organization in the nation. The organization is dedicated to improving health and well-being in partnership with members, patients and the community, and provides a full-range of health care delivery and health plan services including insurance, administration and health and well-being programs. HealthPartners serves more than 1.5 million medical and dental health plan members nationwide, and is the top-ranked commercial plan in Minnesota.

HealthPartners has nearly three decades of expertise in providing Medicare and Medicaid products. We have long-standing contracts with the federal and state government to serve beneficiaries. We currently provide coverage to approximately 160,000 Medicare and Medicaid program enrollees. The HealthPartners Minnesota Senior Health Options (MSHO) Plan is a Fully-Integrated Dual Eligible Special Needs Plan (FIDE SNP), and currently includes over 3,200 members in 12 different counties in Minnesota.

Due to our small membership size, we were unable to conduct a statistical analysis of our MSHO plan (H2422, D-SNP only contract) and our Freedom plan (H2462, Cost contract). However, we are able to provide a more qualitative comparison to demonstrate how Stars measures do not reflect the needs of our MSHO SNP members.

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Appropriate Measures

Our MSHO plan scores consistently high in the Stars measures, maintaining a 4.5 Star rating for the past three years. However, to achieve and maintain these scores, we must focus on measures that do not best serve our frail, elderly members. If the Stars measures better reflected the unique needs of our dual-eligible members, we would be able to devote more resources to better serving these needs.

We agree with the SNP Alliance comments that the "current Medicare Stars measures are biased toward average Medicare beneficiaries, not high-risk/high-need populations[1] and that current measures do not adequately address the needs of SNP members. According to the National Quality Forum (NQF); "there is a large body of evidence that there are disparities in health and healthcare related to some sociodemographic factors" [2].

HealthPartners also supports the findings of the recently released Inovalon study on Dual Eligible Performance on Stars[3]. The study found that dual eligible beneficiaries have different sociodemographic profiles than non-duals. These profiles result in lower performance in the dual population in 10 of the 1 measures evaluated (56%) and on of the current Star measures studied (75%)[3].

HealthPartners agrees with and supports the NQF recommendation to include sociodemographic and socioeconomic status in risk adjustment methodology. We also support the recommendations from the SNP Alliance to develop new Star Measures specifically for SNPs, weight current measures appropriately and evaluate the validity and reliability of self-reported measures[4].

Social Determinants of Health and Socio-Economic Status (SES)

HealthPartners agrees with the core principles listed in the National Quality Forum's (NQF) Risk Adjustment and Socioeconomic Status[1] report and applaud the NQF's desire to promote fair and accurate measurement practices. The report's conclusion that existing techniques may increase disparities is deeply concerning—it should be seriously considered and empirically analyzed.

The social determinants of health affirm that age, minority status, educational attainment and income all contribute to one's health status. The demographics of our FIDE SNP population illustrate that this population is at much higher risk of poor health outcomes.

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[1] SNP Alliance Comments on MAP Measures: June 13, 2014 Report on Dual Eligibles, SNP Alliance, July 2, 2014.
[2] Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors, National Quality Forum, August 15, 2014.
[3] An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures: Part 1: Member Level Analysis, Inovalon, October 2014.
[4] Restructuring Stars for High-Risk Groups, SNP Alliance, July 14, 2014.

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CAHPS Measures

Below please find our comparison between Medicare CAHPS MSHO and Freedom Stars and raw, non-case-mix adjusted scores. We are highlighting the non-case-mix adjusted scores to illustrate the true difference between the scores of the populations. We have indicated with an asterisk the measures for which we have similar processes and practices for both our MSHO and Freedom plans but the MSHO plan's star rating and CAHPS scores are lower than Freedom's rating and scores.. This is an indicator that SNP members view their care and plan coverage and benefits very differently than members in pure Medicare MA, PDP and Cost plans, likely due to factors outside health plans' control. Additionally, our MSHO members have a richer health benefit set than do Freedom members due to the integration of Medicare and Medicaid services. A richer benefit generally leads to improved health outcomes as reflected by higher CAHPS scores. However, as illustrated in the table below, this is not the case for our MSHO plan.

CAHPS Key Measures	201 MSHO Stars/Scores (H2422)	201 Freedom Stars/Scores (H2462)	Raw Score Gap (compared to Freedom)
C23: Getting Needed Care*	4/61%	5/72%	-11
C24: Getting Appointments and Care Quickly*	5/54%	5/64%	-10
C25: Customer Service*	4/76%	5/84%	-8
C25: Customer Service*	4/76%	5/84%	-8
C26: Rating of Health Care Quality*	4/60%	5/72%	-12
C27: Rating of Health Plan	5/77%	5/76%	=
C28: Care Coordination	5/72%	5/76%	=
D06: Rating of Drug Plan	5/73%	5/65%	+8
D07: Getting Needed Prescription Drugs*	3/75%	5/84%	-9

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We have concerns about the use of measures from the CAHPS survey. The CAHPS survey is currently over 90 questions in length, making it difficult for members to complete in entirety. Also, FIDE SNP members receive two versions, one for Medicare and one for Medicaid, leading to survey fatigue. We are encouraged that starting in 2015 our MSHO members will only receive the Medicare CAHPs survey. We believe the validity and reliability of self-report surveys must be questioned for beneficiaries with intellectual disabilities or cognitive disorders such as dementia. Nationally recognized researchers have indicated that self-report questions should be limited to those that can be addressed by individuals to whom they are targeted.

Recommendations

To better reflect the SNP population through CAHPS, we recommend the following improvements:

1. Self-reported measures should be retired or differentiation made for SNP products.

If the CAHPS continues, we recommend CMS:

2. Develop a CAHPS- modified survey, like HOS-M, for SNPS and make it shorter and easier to complete to enhance response rates.
3. Create a SNP-specific survey to identify issues of importance to SNP beneficiaries in general, such as satisfaction with care management services.
4. Consider establishing different cut points in relation to specific populations or the use of confidence intervals or other methods to account for variation in performance and prevent plans from being penalized for serving high-risk populations known to bias plan star ratings.
5. We believe data for screenings, prevention rates and provider practices, such as use of HIT, should be collected through alternative means such as claims and other administrative data.
6. CMS must develop a methodology to account for differences in socio-economic characteristics to avoid biased quality results that inappropriately penalize SNPs serving disadvantaged populations.

Health Outcome Survey (HOS) Measures

The Sociodemographic factors described above contribute directly to our Stars scores through the Health Outcomes Survey (HOS) measures (C05, C06, C07, C20, and C21). Attached please find the demographic breakdown of our HOS respondents by plan as compared to the total HOS respondents. Please note the uniqueness of our MSHO SNP plan respondents as compared to the overall total and our Cost plan. The SNP members who respond to the survey are older (42.3% above 80 years old), majority female (70.4%), more diverse (38.6% minority), living alone (79.5%), have low educational attainment (40.2% did not graduate high school), and are of a much lower income bracket (72.7% below $20,000

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per year). Please also note the low number of respondents (around 189). These HOS demographics also demonstrate that the Dual status is a proxy for socio-economic status (SES).

This demographic information further illustrates the needs of the population we serve in our SNP. Our SNP members are more frail and elderly, and therefore have a lower baseline level of health. Additionally, they are less likely to have experienced positive health outcomes. See the table below for our HOS scores.

HOS Measure	201 MSHO Stars/Scores (H2422)
C05: Improving or Maintaining Physical Health	5/69%
C06: Improving or Maintaining Mental Health	1/75%
C07: Monitoring Physical Activity	2/50%
C20: Improving Bladder Control	2/38%
C21: Reducing the Risk of Falling	5/81%

We credit our success and improvement in C21: Reduce the Risk of Falling to increased and intensive work on this measure, including supplying falls prevention kits to all members through CMS-approved supplemental benefits.

An example of how a HOS measure does not appropriately measure our SNP population is in C07: Monitoring Physical Activity. The HOS question states: "In the past 12 months, did you talk with your doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise." However, with our frail and elderly population, providers are most likely discussing activities of daily living, not referring to it as "physical activity". When a member is asked this question directly, he or she may not associate the daily activity or balance conversation with physical activity.

Another concern with the HOS is that it is only translated into Spanish. Only 3% of our SNP population speaks Spanish whereas close to 25% of our SNP population speaks a different non-English language, the highest percent speaking Vietnamese at 11%. In addition, the inability to use interpreter services to complete the survey presents significant barriers. Therefore, the HOS is missing an important segment of our population and does not take into account the unique cultural and linguistic demographic needs or our SNP population.

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As mentioned in the CAHPS section above, we are concerned with the validity of self-reported data from surveys completed by beneficiaries with developmental or intellectual disabilities or cognitive disorders such as dementia. It is unreasonable to expect a beneficiary with cognitive deficits to remember receiving treatments that may have occurred weeks or months before the survey. We are also concerned that the survey is biased against beneficiaries who are impacted by low socio-economic status and other social determinants of health such as dually eligible beneficiaries as this population is less likely to utilize preventive services for a variety of reasons such as poor health literacy and difficulty in accessing preventive services.

Healthcare Effectiveness Data Information Set (HEDIS)

The results from the Inovalon study clearly demonstrate that the Stars measures do not adequately measure SNPs due to their unique and high needs populations. The study found that duals perform significantly worse on 10 of 18 measures (56%) and on 6 of the 8 current Star measures (75%) but do perform significantly better o 5 of 18 measures (28%), all of which are related to drug treatment[5].

We see similar patterns between our MSHO SNP plan and our Medicare Cost plan, especially when we drill down to the raw scores. While our Star scores are the same or similar, a closer look at the raw scores show how our MSHO plan is often on the cusp of a lower Star score. Only one of our HEDIS measures has a raw score above that of Freedom, and it is only 1% higher (C18).

Se below for comparison of our HEDIS scores. Se below for comparison of our HEDIS scores.

HEDIS Key Measures	201 MSHO Stars/Scores (H2422)	201 Freedom Stars/Scores (H2462)	Score Gap (compared to Freedom)
C01: Colorectal Cancer Screening	5/67%	5/86%	-19%
C02: Cardiovascular Care – Cholesterol Screening	4/85%	5/94%	-9%
C03: Diabetes Care – Cholesterol Screening	4/89%	5/94%	-5%

[5] An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures: Part 1: Member Level Analysis, Inovalon, October 2014.

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C08: Adult BMI Assessment	5/96%	5/98%	-2%
C13: Osteoporosis Management in Women who had a fracture	1/8%	1/16%	-8%
C14: Diabetes Care –Eye Exam	5/77%	5/83%	-6%
C15: Diabetes Care – Kidney Disease Monitoring	4/92%	5/95%	-3%
C16: Diabetes Care – Blood Sugar Controlled	5/86%	5/91%	-5%
C18: Controlling Blood Pressure	5/80%	5/79%	+1%

Recommendations:

1. The star rating performance gap between SNP and non-SNP MA plans has been documented and addressed by a variety of organizations through well-researched studies. We recommend that CMS continue to review this research and make modifications to the star ratings program to account for the unique challenges in serving a dually eligible population.
2. Case-mix adjust HEDIS/HOS to account for SES impacts.
3. Revise HCC risk adjustment methodologies to account for SE impacts for SNPs.
4. Apply a SNP factor based on the concentration of duals in a SNP. This factor would recognize the total number of duals per SNP and provide an adjustment, similar to the i-Factor, with a maximum of .4. This factor would be applied to the overall calculated score.

Prescription Drug Event (PDE) Measures

While HealthPartners MSHO does well on the medication adherence measures, the plan is at a disadvantage with the High Risk Medication measure. In our Cost plan, we have instituted formulary restrictions for the class of 1st generation antihistamines. However, under the Medicaid wrap portion of the MSHO benefit set, the MSHO population is able to purchase over the counter products containing

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Benadryl and other first generation antihistamines. This wrap, while crucial for members to receive and afford needed medications, restricts our ability to effectively manage the use of antihistamines through formulary restriction. It is highly likely that our Cost and PDP populations are also using over the counter 1st generation antihistamine-containing products, but these uses are not captured in Prescription Drug Event (PDE) and thus this disproportionally harms SNPs on that measure. Our MSHO plan has consistently scored lower than our Cost plan on this measure, with a 2 Star (11%) rating in the 201 Stars, as opposed to Freedom's Star (9%).

Below please find the PDE measures of our plans. As with the HEDIS data, the difference in scores is masked by similar star ratings, but a drill down to the raw data scores shows consistently lower raw scores for our MSHO Plan. Below please find a comparison of our PDE measures.

PDE Key Measures	201 MSHO Stars/Scores (H2422)	201 Freedom Stars/Scores (H2462)	Score Gap (compared to Freedom)
D09: High Risk Medications	3/11%	4/9%	-2%
D10: Diabetes Treatment	2/79%	2/82%	-3%
D11: Medication Adherence for Diabetes Medications	5/83%	5/88%	-5%
D12: Medication Adherence for Hypertension	4/81%	5/88%	-7%
D13: Medication Adherence for Cholesterol	4/81%	5/86%	-5%

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Final Recommendations

The HealthPartners MSHO Special Needs Plan scores consistently high in the Stars measures. However, to achieve and maintain these scores, we must focus on measures that do not best serve our members. As indicated in the studies cited, the social determinants of health and socioeconomic status directly impacts a person's health, and our MSHO members are at a greater risk of poor health outcomes due to these external factors. Based on these analyses, HealthPartners is in agreement with both the Inovalon study and the SNP Alliance comments and recommendations regarding this RFI, especially the long-term goal of modifying the Star-rating program to permanently account for effects of social determinants of health.

We also support the SNP Alliance's recommendations outlined in the July 14, 2014 position paper "Restructuring Stars for High-Risk Groups"[6]. Included in these recommendations is the recommendation to evaluate the validity and reliability of self-reported HOS and CAHPS-related measures by persons with intellectual, mental and behavioral health conditions that compromise their self-report abilities.

[6] Restructuring Stars for High-Risk Groups, SNP Alliance, July 14, 2014.